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

In the Matter of the First Amended Accusation Against: Khoi Manh Le, M.D. Physician's and Surgeon's Certificate No. A 77166 Respondent.	Case No.: 800-2018-040491

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 March 25, 2022.

IT IS SO ORDERED: February 24, 2022.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
LYNETTE D. HECKER
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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 First Amended Accusation Against: **KHOI MANH LE, M.D.** **6323 No. Fresno St., Ste. 105** **Fresno, CA 93710-5282** **Physician's and Surgeon's Certificate No. A 77166** Respondent.	Case No. 800-2018-040491 OAH No. 2021030061 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the First Amended Accusation.

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 Lynette D. Hecker, Deputy Attorney General.

2. Khoi Manh Le, M.D. (Respondent) is represented in this proceeding by attorney Marvin Firestone, MD, JD, whose address is: Marvin Firestone, MD, JD & Assoc., LLP, 1700 South El Camino Real, Ste. 408, San Mateo, CA 94402.

3. On or about November 21, 2001, the Board issued Physician's and Surgeon's Certificate No. A 77166 to 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. 800-2018-040491, and will expire on January 31, 2023, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2018-040491 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on June 10, 2021. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of First Amended Accusation No. 800-2018-040491 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2018-040491. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in First Amended Accusation No. 800-2018-040491, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case or factual basis with respect to the charges and allegations in First Amended Accusation No. 800-2018-040491, that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 77166 to disciplinary action, and Respondent hereby gives up his right to contest those charges.

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.

RESERVATIONS

12. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding

CONTINGENCY

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

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14. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in First Amended Accusation No. 800-2018-040491 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.

15. 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.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 77166 issued to Respondent Khoi Manh Le, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years, to take effect immediately and to run concurrent to, but separate and apart from, the five (5) years imposed by the probationary order in case no. 800-2015-016568, 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.

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

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the

Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

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

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

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. 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.

STANDARD CONDITIONS

4. 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.

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

6. 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.

7. 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.

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8. 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.

9. 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.

10. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than

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

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

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

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

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

11. 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.

12. 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.

13. 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.

14. 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.

15. 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 First Amended Accusation No. 800-2018-040491 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Marvin Firestone, MD, JD. 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: 9-21-2021

KHOI MANH LE, M.D.
Respondent

I have read and fully discussed with Respondent Khoi Manh Le, 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: 9/23/21

MARVIN FIRESTONE, MD, JD
Attorney for Respondent

ENDORSEMENT

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

DATED: 9/24/2021

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

LYNETTE D. HECKER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

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

In the Matter of the First Amended Accusation Against: **Khoi Manh Le, M.D.** **6323 N. Fresno St., Ste. 105** **Fresno, CA 93710** **Physician's and Surgeon's Certificate No. A 77166,** Respondent.	Case No. 800-2018-040491 **FIRST AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this First Amended 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 November 21, 2001, the Medical Board issued Physician's and Surgeon's Certificate Number A 77166 to Khoi Manh Le, 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 January 31, 2023, unless renewed.

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JURISDICTION

3. This First Amended 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 states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

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 that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The 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.

DEFINITIONS

7. Atrial fibrillation (A-fib) is an abnormal heart rhythm that originates in the top chambers of the heart (atria). When the heart beats normally, the electrical impulse begins at the sinoatrial (SA or sinus) node in the right atrium. The SA node produces the electrical impulses that set the rate and rhythm of the heart beat. The electrical activity spreads through the walls of the atria and causes them to contract. The electrical impulse then crosses the AV node and spreads down to the ventricles, causing them to contract. This creates the heart beat. In patients with A-fib, the SA node does not direct the heart's electrical rhythm. Instead, many different impulses rapidly fire at once. This causes a very fast, chaotic rhythm in the atria. Because the electrical impulses are so fast and chaotic, the atria cannot contract and/or effectively squeeze blood into the ventricle. Treatment goals for patients with A-fib include restoring a normal heart rhythm (sinus rhythm), controlling the heart rate, reducing symptoms, and reducing the risk of

blood clots and stroke. Many treatment options are available, including lifestyle changes, medications, catheter-based procedures and surgery.

8. Cardiac ablation is a procedure that can correct heart rhythm problems (arrhythmias). Isolation is a type of ablation. Cardiac ablation works by scarring or destroying tissue in the heart that triggers or sustains an abnormal heart rhythm. In some cases, cardiac ablation prevents abnormal electrical signals from entering the heart and, thus, stops the arrhythmia. Cardiac ablation usually uses long, flexible tubes (catheters) inserted through a vein or artery in the groin and threaded to the heart to deliver energy in the form of heat or extreme cold to modify the tissues in the heart that cause an arrhythmia. Cardiac ablation is sometimes performed via open-heart surgery, but it is often done using catheters, making the procedure less invasive and shortening recovery times. The location of ablation and isolation procedures are identified by the organs or veins/arteries in which they are performed (i.e. pulmonary vein isolation, posterior roof and/or wall ablation, etc.).

9. Angiography is examination by X-ray of blood or lymph vessels, carried out after introduction of a substance that will show up on X-ray.

10. The ankle-brachial index test compares the blood pressure measured at the ankle with the blood pressure measured at the arm. A low ankle-brachial index number can indicate narrowing or blockage of the arteries in the legs. The ankle-brachial index test is a quick, noninvasive way to check for peripheral artery disease (PAD) which occurs when narrowed arteries reduce the blood flow to the limbs.

11. Cardiac catheterization is a procedure used to diagnose and treat certain cardiovascular conditions. During cardiac catheterization, a long, thin tube called a catheter is inserted in an artery or vein in the groin, neck, or arm and is threaded through blood vessels to the heart. Using this catheter, doctors can do diagnostic tests.

12. A CHADS VASC score is a clinical prediction tool for estimating the risk of stroke in patients with non-rheumatic A-fib. Such a score is used to determine whether or not treatment is required with anticoagulation therapy or antiplatelet therapy, since A-fib can cause stasis of blood in the upper heart chambers, leading to the formation of a mural thrombus that can dislodge into

the blood flow, reach the brain, cut off supply to the brain, and cause a stroke. A high score corresponds to a greater risk of stroke, while a low score corresponds to a lower risk of stroke.

13. An echocardiogram (ECHO) is a test that uses high frequency sound waves (ultrasound) to make pictures of the heart. The test is also called echocardiography or diagnostic cardiac ultrasound.

14. An electrophysiology (EP) study is a test used to understand and map the electrical activity within the heart. It is used to understand the electrical signals moving through the heart to make it beat in people whose bodies produce ineffective or chaotic electrical signals that cause the heart to beat incorrectly.

15. An electrocardiogram (also called EKG or ECG) records the electrical signals in the heart. It is a common test used to detect heart problems and monitor the heart's status in many situations.

16. Ejection fraction (EF) measures the amount of blood pumped out of the heart's lower chambers, or ventricles. It is the percentage of blood that leaves the left ventricle when the heart contracts. EF can be measured via EKG, MRI, or a nuclear stress test. Generally, a normal EF is 55% to 75%.

17. Hypotensive means relating to or suffering from abnormally low blood pressure.

18. Ischemia is a condition in which the blood vessels become blocked, and blood flow is stopped or reduced. When blood flow is diminished to a body part, that body part also does not receive adequate oxygen. Ischemia can occur anywhere in the body, including the brain (cerebral ischemia), heart (ischemic heart disease, myocardial ischemia, or cardiac ischemia), legs (critical limb ischemia – a form of peripheral artery disease), and intestines (mesenteric or bowel ischemia).

19. Nonspecific ST changes refer to changes in the T waves (such as inversion or flattening) and ST segments (such as ST depression) on the electrocardiogram that do not follow an anatomic distribution and are not diagnostic of any one condition.

20. A nuclear stress test uses radioactive dye and an imaging machine to create pictures showing the blood flow to the heart. The test measures blood flow at rest and upon exertion,

showing areas with poor blood flow or damage in the heart. The test usually involves injecting radioactive dye, then taking two sets of images of the heart — one at rest and another after exertion or, if the patient is unable to exercise, after a medication is given that causes stress to the heart which is called a pharmacologic nuclear stress test.

21. Obstructive coronary artery disease is the gradual narrowing or closing of arteries that supply the heart with blood. This blockage is usually caused by a build-up of plaque (atherosclerosis).

22. Obstructive sleep apnea is a potentially serious sleep disorder. It causes breathing to repeatedly stop and start during sleep. There are several types of sleep apnea, but the most common is obstructive sleep apnea. This type of apnea occurs when the throat muscles intermittently relax and block the airway during sleep.

23. A sinus rhythm is any cardiac rhythm in which depolarization of the cardiac muscle begins at the sinus node. It is characterized by the presence of correctly oriented P waves on the electrocardiogram (EKG). Sinus rhythm is necessary, but not sufficient, for normal electrical activity within the heart. Normal sinus rhythm is defined as the rhythm of a healthy heart. It means the electrical impulse from the sinus node is being properly transmitted. In adults, normal sinus rhythm usually accompanies a heart rate of 60 to 100 beats per minute. However, normal heart rates vary from person to person.

24. Tachycardia is a heart rate of more than 100 beats per minute. A normal heart rate is 60 to 100 beats per minute. One who is experiencing tachycardia is said to be "tachycardic." Supraventricular tachycardia (SVT), also called paroxysmal supraventricular tachycardia, is defined as an abnormally fast heartbeat that originates from a location within the heart above the bundle of His. It is a broad term that includes many forms of heart rhythm problems (heart arrhythmias) that originate above the ventricles (supraventricular) in the atria or AV node. AV-nodal reentrant tachycardia (AVNRT) is a type of abnormal fast heart rhythm. It is a type of SVT. AV nodal reentrant tachycardia is the most common regular SVT. Ventricular tachycardia (VT) is a heart rhythm disorder (arrhythmia) caused by abnormal electrical signals in the lower chambers of the heart (ventricles). Atrial tachycardia (AT) is a type of rapid heart rhythm that

occurs when the electrical signal that controls the heartbeat starts from an unusual location in the upper chambers (atria) and rapidly repeats, causing the atria to beat too quickly. The difference between A-fib and AT is that A-fib is a condition which causes rapid heart rate and irregular heartbeat whereas AT causes rapid heart rate while the heartbeat is regular. In A-fib, abnormal impulses are produced in the atrium and the atria beat irregularly. They contract partially and rapidly and are not able to pump adequate blood.

25. Tachyarrhythmia is any disturbance in the heart's rhythm, regular or irregular, resulting in a heart rate over 100 beats per minute.

26. Telemetry is an observation tool that allows continuous monitoring and analysis of the electrical activity of a heart including heart beat variability and inferring beats to alert the patient and/or medical personnel of potential A-fib or other cardiac events.

27. Troponin is a protein found in the cardiac and skeletal muscles. When the heart is damaged it releases troponin into the bloodstream.

28. VT1 is called the first threshold of ventilation (the exchange of air between the lungs and the atmosphere). It is a marker of intensity that can be observed in a person's breathing at a point where lactate begins to accumulate in the blood. As the intensity of the exercise begins to increase, VT1 can be identified at the point where the breathing rate begins to increase. VT2 is the second ventilatory threshold. It is a higher marker of intensity than VT1. At VT2, lactate has quickly accumulated in the blood and the person needs to breathe heavily. At this rapid rate of breathing, the exerciser can no longer speak. The exercise duration will necessarily decrease due to the intensity level. VT2 can also be called the anaerobic threshold or lactate threshold.

FACTUAL ALLEGATIONS

CIRCUMSTANCES RELATED TO PATIENT A[1]

29. At the time she was treated by Respondent, Patient A was an 87-year-old woman with a history of high blood pressure, a slow/underactive thyroid, paroxysmal A-fib, and was wheelchair-bound from an ankle fracture. In or about April of 2016, approximately six months

[1] To protect their privacy, individual patient names are not identified in this First Amended Accusation.

before she was treated by Respondent, Patient A had a left middle cerebral artery stroke with residual deficits. Following the stroke, she was prescribed a medication to thin her blood to prevent the formation of blood-clots. However, prior to seeing Respondent, Patient A developed blood in her urine, so her blood-thinner medication was discontinued and she was placed on aspirin. Thereafter, Patient A was diagnosed with kidney nodules and a possible bladder tumor for which a biopsy was planned.

30. While on aspirin, Patient A was hospitalized with blood in her urine again, on or about October 26, 2016. In the ER, her aspirin was stopped, a catheter was placed, and bladder irrigation was performed.

31. The next day, Respondent was consulted and saw Patient A regarding her A-fib, which was intermittent. Respondent recommended catheter ablation, as he felt it would allow "temporary cessation of anticoagulation while minimizing risk of stroke." That same day, an abdominal and pelvic CT showed renal nodules growing outward from the kidney, possible cysts at the right bladder base which were less evident, favoring a resolving clot and less likely bladder tumor.

32. On or about that same day, Patient A was evaluated by a palliative care physician who noted Patient A was not sure she wanted to undergo all of the medical procedures. He concluded "it would not be unreasonable for the patient to decline any further intervention given possible complications and risks of procedures, except those that would add comfort and quality to her life."

33. The next day, on or about October 28, 2016, Respondent performed pulmonary vein isolation on Patient A in which bidirectional vein block was assessed, and lateral mitral annulus, left roof, and cavotricuspid isthmus ablation were performed. Following the procedure, Patient A was noted to be bradycardic, having an abnormally slow heartbeat, down to the 40s at night, on flecainide (a medication to treat certain types of serious, possibly fatal, irregular heartbeats) and metoprolol (a medication to treat high blood pressure). Flecainide and metoprolol were therefore stopped. Patient A was discharged on or about October 30, 2016.

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CIRCUMSTANCES RELATED TO PATIENT B

34. At the time he was treated by Respondent, Patient B was a 56-year-old man with type II diabetes, end stage renal disease (for which he was on dialysis), coronary artery disease (for which he had a stent placed to the right coronary artery in or about 2016), high cholesterol, high blood pressure, narrowing of the spinal canal in his neck that caused pressure on the nerves that travel through the spine resulting in weakness in all four of his limbs since in or about October of 2016, obstructive sleep apnea, SVT, and prior cardiac ablation in or about August of 2016.

35. Patient B was hospitalized on or about May 3, 2017, with feelings of a fluttering or pounding heart followed by chest pain. At that time, he had an infected bedsore. Patient B was also noted to have episodes of SVT on the test readings and was felt to be AV nodal reentrant, which is the most common type of SVT. He became tachycardic and hypotensive after dialysis and was felt to be in SVT. Patient B's rhythm reportedly responded to adenosine, intravenous fluids and intravenous Lopressor.

36. During the hospitalization, Patient B was seen by Respondent on or about May 3, 2017. Respondent's consult note on Patient B does not report ischemic EKG changes or troponin levels. However, elsewhere in the chart it is noted that his troponin was initially negative, but peaked at 3.8 and that EKG showed sinus tachycardia and signs of a reversible ischemia (inferolateral ST depression). Coronary angiography was recommended and performed which showed moderate in-stent disease of the right coronary with no obstructive disease.

37. On or about May 9, 2017, Patient B underwent electrophysiology study and catheter ablation. Respondent noted catheter manipulation induced SVT with earliest retrograde atrial activation at the lateral mitral annulus (presuming Patient B had a left lateral accessory pathway causing his SVT, based on the atrial activation pattern during spontaneous catheter-induced SVT). Respondent performed ablation of a presumed accessory pathway with pacing from the RV until eccentric activation terminated. Respondent then performed A-fib ablation. Patient B's pulmonary veins were isolated and posterior wall ablation was also performed. Respondent did not anticoagulate Patient B following the procedure. Patient B was discharged from the hospital on or about May 15, 2017.

CIRCUMSTANCES RELATED TO PATIENT C

38. At the time she was treated by Respondent, Patient C was a 52-year-old woman with morbid obesity, asthma, high blood-pressure, high cholesterol, chronic marijuana use (up to 5-6 cigarettes/day), and a slow/underactive thyroid. Patient C presented to the hospital on or about April 29, 2017, with vomiting, diarrhea for 2 days, and dizziness for 1 day prior to admission. She reported fainting or near fainting the day prior to admission. Her blood pressure was 93/65 and her pulse was 98 bpm on admission. She did not have a fever and her potassium was 2.9. Her urine toxicology screen was positive for cannabis. An EKG showed multifocal (or multiform) AT and no ST-T changes. Patient C was also going in and out of A-fib on admission, with rates up to 150 bpm. Per ER nurse notes, Patient C had A-fib at 100-150 bpm, but no shortness of breath or chest pain. Her rhythm spontaneously converted to sinus 90-120 bpm at rest. Patient C was admitted to telemetry and received intravenous fluids along with potassium supplementation. Patient C was diagnosed with norovirus causing acute gastroenteritis.

39. Patient C's EKGs on or about April 29, 2017, at or about 00:35 and 10:39, show sinus rhythm and runs of multifocal AT, irregular, at rates 100-150 bpm. Her EKGs from on or about May 2, 2017, and on or about May 3, 2017, show sinus rhythm. Her rhythm strips from that hospitalization primarily show sinus rhythm. On or about April 29, 2017, at or about 19:02, Patient C had an episode of AT at 130 bpm. Tracings from on or about April 30, 2017, at or about 10:49 and 16:48, show nonsustained AT at 110 bpm. On or about May 1, 2017, at or about 00:24, Patient C had a heart rate of 130 bpm that lasted for approximately 6 seconds.

40. On or about May 1, 2017, an echocardiogram was performed on Patient C which showed normal left ventricle function and moderate narrowing of her aortic valve. Patient C was seen by Respondent and reported that for over a year, she had paroxysmal, or intermittent, A-fib and symptoms of dizziness. Respondent discussed catheter ablation with Patient C and her family. On or about May 2, 2017, Respondent performed pulmonary vein isolation for paroxysmal A-fib. Patient C was discharged on or about May 3, 2017.

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CIRCUMSTANCES RELATED TO PATIENT D

41. Patient D was a 70-year-old man with diabetes, congestive heart failure, and an ICD (implantable defibrillator). Patient D was from the Los Angeles area and was driving his truck through Fresno in the evening of on or about May 22, 2017, when he experienced several ICD shocks at or around 23:00 hours. Patient D was asymptomatic when he presented to the hospital ER that evening, and stated that he had not taken his carvedilol (medication for high blood pressure and heart failure) that day. Patient D reported a remote history of ICD shocks and a history of congestive heart failure for 10 years. His home medications included: furosemide, metolazone, carvedilol, rivaroxaban, allopurinol, glipizide, vitamin D, co Q 10, Tylenol #3, and potassium. In the ER, Patient D remained asymptomatic. His pulse was initially 108 bpm, but decreased to 67 bpm and his blood pressure fell to 102/47. His oxygen saturation was 98% on room air. His potassium was low at 3.2 and his magnesium was also low at 1.3. His creatinine was 1.6 with BUN 43. His initial troponin was 0.182 at or about 00:25, on or about May 23, 2017, but increased to 3.8 at or about 6:07 hours. In the ER, Patient D's ICD was interrogated (i.e. its firing history was checked) and it was found to have fired 6 times inappropriately for rapidly conducted A-fib at rates of 165 bpm. Prior to and following the inappropriate VT detection, the device was found to have appropriately detected A-fib. Patient D's VT1 rate was 150 bpm, his VT2 rate was 180 bpm, his VT detect rate was 220 bpm. The device interrogation showed it was implanted on or about June 6, 2016, and was last interrogated on or about January 13, 2017. There were no previous shocks but VT detections, nonsustained, without therapies, in or around February of 2017, since the last interrogation, and prior to the shocks on or about May 22, 2017. Patient D was given intravenous fluids, oral carvedilol and intravenous magnesium supplementation in the ER.

42. Patient D was seen by Respondent on or about May 23, 2017. Respondent attempted to contact Patient D's primary cardiologist. Respondent felt that further rate control medication could not be given to Patient D due to his borderline BP (90-100 systolic). Respondent recommended catheter ablation for Patient D for A-fib. An ECHO done on or about May 24, 2017, reported an EF of 20-25%. Respondent performed pulmonary vein isolation, roof and left

posterior wall ablation on Patient D or about May 24, 2017. Patient D was discharged later on or about that same day.

CIRCUMSTANCES RELATED TO PATIENT E

43. Patient E is a 65-year-old man who was referred to Respondent for preoperative cardiac evaluation prior to spine surgery. Patient E saw Respondent on or about January 7, 2019. Patient E complained of dizziness, but had no chest pain, difficulty breathing, or feelings of a fast-beating, fluttering, or pounding heart. Patient E had a history of smoking a pack of cigarettes every day for the past 42 years. His blood pressure was 124/56. His pulse was 82 beats per minute. His body mass index was 26 and an EKG showed sinus rhythm at 82 bpm, normal axis, and nonspecific ST changes.

44. On or about that same day, Patient E underwent pharmacologic cardiac stress nuclear testing as well as an ECHO and an ankle-brachial index. Respondent noted discussing the results of all of these tests with Patient E and that he recommended a cardiac catheterization – which Patient E declined. Respondent prescribed Crestor, 20 mg daily, which Patient E declined to take. However, Respondent failed to note any details regarding Patient E's complaint of dizziness in the history, such as precipitating or alleviating factors and/or duration and severity of his dizziness. Respondent also failed to discuss in the assessment, or plan section of the note, any further evaluation and treatment of Patient E's dizziness. Thereafter, Patient E requested copies of his records and testing images from Respondent's office, but did not return to see Respondent for any follow-up visit.

FIRST CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence)

45. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated acts of negligence. The circumstances are set forth in paragraphs 29 through 44, which are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

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PATIENT A

46. The primary indication for catheter ablation is to reduce patient symptoms and improve quality of life. Therefore, prior to undergoing catheter ablation, it is important to confirm that the patient's symptoms (palpitations, fatigue, or effort intolerance) result from A-fib and to assess their severity.

47. For patients with A-fib, the standard of care is that catheter ablation is reasonable for "selected older patients" over 75 years old, with similar indications as for younger patients. This is a class IIa indication, meaning there is some divergence of opinion, but that weight of evidence is in favor of treatment. For younger patients, catheter ablation for A-fib is a class I indication (definitely indicated) for symptomatic patients who are refractory to or intolerant of at least one class I or class III antiarrhythmic agent. A-fib catheter ablation has a class IIa indication for symptomatic patients with paroxysmal A-fib prior to therapy with a class I or III antiarrhythmic agent. Procedural complications of the ablation procedure are increased in older patients, procedural efficacy is reduced, and need for concomitant antiarrhythmic therapy is greater.

48. In this case, there is no documentation that Patient A had any symptoms due to A-fib. She did not have palpitations, dyspnea, chest pain, dizziness, or lightheadedness, for example. Further, as she was elderly, age 87, she was significantly debilitated and expressed a reluctance to undergo medical procedures. Catheter ablation for A-fib was inappropriate. The procedure would not improve her quality of life or alleviate symptoms. Additionally, procedure risks are increased in the elderly. As she had hematuria, possibly due to a tumor, she was at elevated bleeding risk from heparin anticoagulation which is required during the catheter ablation procedure itself.

49. Respondent's recommendation for catheter ablation for A-fib in Patient A, an 87-year-old woman, without symptoms due to A-fib, that was not indicated and resulted in Patient A being subjected to procedural risks with minimal benefit, constitutes negligence.

50. For patients with A-fib, the standard of care is that anticoagulation recommendation is based on the CHADS VASC score, regardless of whether ablation is performed. Patients may have asymptomatic A-fib before or after ablation. At the time Respondent treated Patient A, both

intra-procedural heparin and oral anticoagulation were recommended for >/=2 months post-procedure. The standard of care dictated that A-fib catheter ablation should not be performed in patients who cannot be treated with anticoagulant therapy during and after the procedure as it may be harmful to the patient and it should not be performed to restore sinus rhythm with the sole intent of obviating the need for anticoagulation. Respondent's failure to recognize an increased stroke risk based on Patient A's CHAD VASC score, not significantly lowered by ablation, and his failure to recognize elevated stroke risk for Patient A based on the lack of ability to safely anticoagulated Patient A shortly before, during, or shortly after the procedure, constitutes negligence.

PATIENT B

51. For patients with SVT who are brought to the electrophysiology laboratory, the standard of care is to perform a diagnostic study to determine the tachycardia mechanism. This data is then used to guide ablation.

52. Respondent presumed that Patient B had a left lateral accessory pathway causing his SVT based on the atrial activation pattern during spontaneous, catheter-induced SVT. Respondent failed to document diagnostic maneuvers to determine the tachycardia mechanism and failed to include details of the mapping procedure, ablation lesions given, or post-procedure tachycardia induction attempts. Respondent's failure to document the diagnostic electrophysiologic study and catheter ablation of a presumed left lateral accessory pathway constitutes negligence.

53. For A-fib catheter ablation, the standard of care for the procedure is that it is performed for symptomatic patients with paroxysmal A-fib who have failed one or more antiarrhythmic agents. For patients with concealed or manifest accessory pathway conduction, ablation of the accessory pathway has been shown to significantly reduce the incidence of A-fib.

54. Patient B was reported to have had A-fib in the past. However, the arrhythmia from the May 2017 admission is reported to be SVT, terminating with intravenous adenosine. The tracings from on or about March of 2017 mainly show a regular, narrow complex tachycardia, with the exception of one occasion on or about March 31, 2017, at or about 17:49 hours, which is

irregular, possibly A-fib, though AT or flutter cannot be ruled out. The patient did not have symptomatic A-fib during the admission in or about May of 2017. There is no documentation of symptomatic A-fib previously for Patient B. Since Patient B reportedly previously had a left sided accessory pathway ablated, it is likely that the risk for A-fib would be significantly reduced. Therefore, further ablation for A-fib, which has added procedural risks, especially in this debilitated patient with infection, was not indicated when Respondent treated him. Further, Respondent failed to anticoagulate Patient B post-procedure, which is not in accordance with standard A-fib ablation guidelines. Respondent's performance of A-fib ablation on Patient B, who had severe debility, documented SVT and reported left sided accessory pathway ablated, and without post-procedure anticoagulation, constitutes negligence.

PATIENT C

55. Patient C was hospitalized with dizziness in the setting of an acute gastroenteritis. She had runs of what appear most likely to be AT. There are P waves clearly visible on or about April 29, 2017, at or about 9:59 on the rhythm strip, as well as on the EKG at or about 11:09 that same day, suggesting AT as the mechanism of her tachycardia, rather than A-fib. Her episodes were nonsustained. It is possible that these arrhythmias were due to volume and electrolyte shifts from Patient C's acute gastroenteritis. Patient C also had chronic marijuana use, which could have contributed to her arrhythmias. It is not clear that her symptoms of dizziness were due to atrial arrhythmia. It is much more likely that her dizziness was caused by dehydration due to gastroenteritis, with nausea, vomiting and diarrhea. A-fib catheter ablation was not indicated. Diagnostic electrophysiologic testing may have been indicated if the atrial tachyarrhythmias persisted, but it would be within the standard of care to be done electively, not in the setting of her acute gastroenteritis.

56. Respondent's recommendation for and performance of catheter ablation for A-fib (pulmonary vein isolation) for Patient C who had nonsustained AT in the setting of acute viral gastroenteritis constitutes negligence.

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PATIENT D

57. The standard of care dictates that catheter ablation for A-fib is indicated for symptomatic patients who have failed a trial of an antiarrhythmic drug. It is a class IIa indication for patients with paroxysmal, symptomatic A-fib who have not had a trial of antiarrhythmic agent. For patients presenting with inappropriate shocks, the first step is to determine the cause of the inappropriate detection and adjust device settings to ensure appropriate detection and avoid further inappropriate therapies. For patients with inappropriate shocks due to high rates in A-fib, the standard of care is to control the ventricular rate with AV nodal blocking drugs, or a rhythm control strategy with use of antiarrhythmic agents. Catheter ablation is a second-line option and used as an immediate treatment for inappropriate shocks.

58. Patient D presented with 5 inappropriate ICD shocks due to rapidly conducted A-fib while travelling. His troponin was 3.8. His EKG on admission showed an A-V paced rhythm. Catheter ablation for A-fib is not indicated as an urgent procedure in this case. Instead, initially his device should have been reprogrammed. His medication, resuming and/or increasing beta-blocker therapy, should also have been adjusted. These treatment options are most likely to avoid further inappropriate shocks. For this patient specifically, additional reasons not to choose ablation as an initial therapy were: (1) he had an elevated troponin, above what would be expected for ICD shocks alone, and myocardial ischemia should be ruled out before performing the elective ablation procedure; and (2) he was travelling from out of town, and for optimal patient care, should be referred back to his local electrophysiologist who implanted the ICD and is most familiar with Patient D's arrhythmia history. Catheter ablation, if indicated, and follow-up could then be performed electively by Patient D's local, primary electrophysiologist. Respondent's recommendation for an urgent A-fib catheter ablation for Patient D who was hospitalized for inappropriate ICD shocks due to A-fib constitutes negligence.

SECOND CAUSE FOR DISCIPLINE

(Recordkeeping)

59. Respondent is subject to disciplinary action under section 2234 and section 2266 for failing to maintain adequate and accurate records. The circumstances are set forth in paragraphs

43 and 44, which are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

PATIENT E

60. The standard of care in medical record keeping is to report the patient's symptoms, as chief complaint, with details provided in the history, and to formulate an assessment and plan.

61. Patient E was referred to Respondent for preoperative cardiac evaluation which Respondent correctly reported as the reason for visit. However, the office note states that Patient E's chief complaint was dizziness. Respondent's failure to note any further details regarding Patient E's complaint of dizziness in the history, such as precipitating or alleviating factors, duration and severity of this symptom, and failure to record any discussion in the assessment or plan section of the note regarding further evaluation and treatment of Patient E's dizziness constitutes negligence and unprofessional conduct.

DISCIPLINARY CONSIDERATIONS

62. To determine the degree of discipline, if any, to be imposed on Respondent Khoi Manh Le, M.D., Complainant alleges that on or about August 31, 2018, in a prior disciplinary action titled In the Matter of the Accusation Against Khoi Manh Le, M.D., before the Medical Board of California, in Case Number 800-2015-016568, Respondent's license was revoked. However, revocation was stayed and Respondent was placed on probation for five (5) years for a substantially related conviction and unprofessional conduct with the following terms and conditions in addition to the Standard Conditions of Probation: Professionalism Program (Ethics Course); Professional Boundaries Program; Psychiatric Evaluation; Psychotherapy; Third Party Chaperone; and Prohibited Practice. That decision is now final and is incorporated by reference as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 77166, issued to Khoi Manh Le, M.D.;

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

3. Ordering Khoi Manh Le, 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: JUN 10 2021

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

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