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

In the Matter of the Accusation Against: Harbinder Singh Chadha, M.D. Physician's and Surgeon's Certificate No. G 84284 Respondent.	Case No.: 800-2017-039857

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 April 4, 2022.

IT IS SO ORDERED: March 3, 2022.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against:

HARBINDER SINGH CHADHA, M.D., Respondent

Agency Case No. 800-2017-039857

OAH No. 2021010496

PROPOSED DECISION

Debra D. Nye-Perkins, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference and telephone on December 20, 21, and 22, 2021, due to the ongoing COVID-19 pandemic.

Robert W. Lincoln, Deputy Attorney General, represented complainant, William Prasifka, Executive Director of the Medical Board of California (board), Department of Consumer Affairs, State of California.

Robert W. Frank, Attorney at Law, Neil, Dymott, Frank, McCabe & Hudson A.P.L.C., represented respondent who was present throughout the hearing.

Oral and documentary evidence was received. The record was closed, and the matter was submitted for decision on December 22, 2021.

PROTECTIVE SEALING ORDER

The name of the patient in this matter is subject to a protective sealing order. No court reporter or transcription service shall transcribe the actual name of the patient but shall instead refer to the patient as Patient A. To protect privacy and confidential personal and medical information from inappropriate disclosure, a written Protective Order Sealing Confidential Records was issued. The order lists the exhibits ordered sealed and governs the release of documents to the public. A reviewing court, parties to this matter, their attorneys, and a government agency decision maker or designee under Government Code section 11517 may review the documents subject to the order, provided that such documents are protected from release to the public.

FACTUAL FINDINGS

Jurisdictional Matters

1. On December 12, 1997, the board issued Physician's and Surgeon's Certificate Number G 84284 to respondent. The certificate is set to expire on June 30, 2023, unless renewed.

2. On December 15, 2020, the board filed accusation number 800-2017-039857 seeking revocation or suspension of respondent's certificate based upon five causes of discipline, all related to respondent's care and treatment of Patient A, namely: (1) gross negligence, (2) repeated negligent acts, (3) incompetence, (4) failure to maintain adequate and accurate records, and (5) failure to participate in an interview by the board without good cause.

3. Respondent timely filed a notice of defense, and this hearing followed.

Summary of Medical Records Regarding Patient A's Medical Treatment

4. On December 27, 2014, Patient A, a 62-year-old male with a history of smoking, fell from a ladder and sustained a serious open left ankle fracture with a large open wound bleeding steadily and was admitted to Sharp Memorial Hospital. On December 28, 2014, respondent performed surgery on Patient A and gave him intravenous prophylactic antibiotics for three days. On December 28, 2014, respondent performed an open reduction internal fixation of Patient A's left ankle with irrigation and debridement and repair of his skin laceration. On December 30, 2014, Patient A was discharged from Sharp Memorial Hospital with oral antibiotics (Keflex) prescribed for two weeks at 500 mg twice per day and instructions to follow up with respondent in two weeks after discharge.

5. On January 12, 2015, respondent saw Patient A for his first follow-up appointment after surgery. On January 12, 2015, respondent obtained X-rays of Patient A's ankle, prescribed pain medication to Patient A, and instructed him to follow up in six weeks for his next appointment on February 23, 2015.

6. Patient A next saw respondent on January 19, 2015, with a chief complaint of "check surgery drainage" and writing on his intake patient form that he still had drainage constantly. Patient A checked the box on the patient intake form indicating that he was "getting better" since his last visit. Respondent wrote in his notes for this visit as follows:

-Medial wound

-Dermis intact

-Dressing change

-No erythema

-CAM walker

-1 cm X 1 cm

Respondent further wrote in the medical records a plan and order that Patient A have dressing changes twice a day for six weeks.

7. Patient A's next visit to respondent was on February 9, 2015. Patient A's intake form for this visit indicated that his chief complaint was "wound check-follow-up." Patient A also checked the box next marked "getting better" in response to the question of how he had progressed since his last visit. Medical records show that respondent ordered home health for Patient A three times per week for four weeks, ordered Patient A to start stretching, provided a DMV disability placard, and prescribed Norco for pain. Respondent wrote that the next follow-up visit would be February 23, 2015.

8. At his next visit on February 23, 2015, Patient A's intake form indicated that his chief complaint was "follow-up," and Patient A put a check in the box next to the response of "getting better" in response to the question of how he had progressed since his last visit. Respondent's notes for this visit state that Patient A had no drainage but did have edema. Respondent obtained an X-ray of Patient A's left ankle on this visit.

9. Medical records show that respondent provided written permission on March 30, 2015, for Patient A to return to work as a teacher with some duty

restrictions as long as Patient A was using crutches. This document also noted that the next follow-up appointment would be May 27, 2015.

10. Patient A's next visit to respondent was on May 13, 2015. Patient A's intake form for this visit indicated that his chief complaint was "drainage on leg," and Patient A put a check in the box marked "getting better" in response to the question of how he had progressed since his last visit. Respondent's only notes regarding his examination of Patient A for this visit were "stitch abscesses-lateral and medial." Respondent referred Patient A to rehabilitation services for therapy evaluation and treatment on this date.

11. Patient A's next visit to respondent was on May 27, 2015. Patient A's intake form for this visit indicated that his chief complaint was "follow-up," and Patient A put a check in the box marked "getting better" in response to the question of how he had progressed since his last visit. Respondent's notes for this visit were "minimal drainage," "4 month -√skin" and "insensate foot." Respondent also obtained an X-ray of Patient A's ankle on this visit that showed the implants and hardware from the surgery were intact. The medical notes for this visit indicate that respondent's plan was to next see Patient A in four months for a follow-up visit. The May 27, 2015, visit of Patient A to respondent was the last visit respondent ever had with Patient A.

12. Medical records show that Patient A saw his primary care physician, Dr. Brian Lenzkes, who referred Patient A to an orthopedic surgeon named Dr. David W. Fabi on August 5, 2015. Dr. Fabi's patient notes regarding that visit provide, in part, as follows:

PHYSICAL EXAMINATION:

On exam, patient is alert and oriented x3, in no apparent distress. The patient appears his stated age.

Examination of the ankle demonstrates some open wounds with drainage. Significant swelling in the ankle. The patient is neurovascularly intact to EHL, FHL, dorsiflexion, plantarflexion, palpable pulses.

RADIOGRAPHIC EXAMINATION:

X-rays demonstrate evidence of non-union of a fracture with significant arthritis.

Wounds are cultured in clinic.

ASSESSMENT AND PLAN:

This is a gentleman with likely infected nonunion status post open reduction and internal fixation of an open fracture.

We will await cultures. We will get a CT scan. The patient will remain nonweightbearing [*sic*]. The patient will likely require hardware removal, clearance of infection and possible revision open reduction and internal fixation. I will consider referring this patient to Foot and Ankle Specialist, Dr. Franz Kopp.

13. Results in the medical records from the wound cultures taken on August 5, 2015, show that Patient A had abnormal results with staphylococcus aureus with

heavy growth in the culture, and Enterobacter species with heavy growth, indicating that Patient A had an infection in his wound.

14. On August 17, 2015, Patient A saw orthopedic foot and ankle specialist, Franz John Kopp, M.D. for evaluation. Dr. Kopp's patient notes for that visit provide, in part, as follows with regard to his physical examination of Patient A's left foot and ankle:

> There is generalized, moderate swelling and edema of the LEFT ankle. There is relative valgus alignment. There are numerous scars as well as operative wounds involving the medial and lateral aspect of the ankle. Small scabs remain both medially and laterally. The patient's bandage is removed today and there is evidence of some purulent drainage on the bandage.....There is generalized tenderness to palpation about the ankle. With firm palpitation, I am able to express some purulent material from the scabbed wound sites medially and laterally. . . . Light touch sensation intact in foot and ankle.

Dr. Kopp further wrote in his patient notes from the August 17, 2015, visit that the X-rays of Patient A's ankle taken on August 5, 2015, and the CT scan taken on August 11, 2015, show that Patient A's medial malleolus fracture "appears partially healed" and his "fibula fracture appears unhealed." He further noted that "[t]here are destructive changes of the ankle (tibiotalar joint) consistent with osteomyelitis." He also noted that there was "an area of lucency involving the central posterior subtalar joint region which may represent a localized infection as well." Dr. Kopp diagnosed Patient A with a left ankle infection, osteomyelitis status post-surgery for his ankle

fracture. Dr. Kopp noted that Patient A "possesses evidence of a significant infection, osteomyelitis" of his ankle. Dr. Kopp recommended that Patient A undergo surgery from Dr. Kopp to remove the hardware from the ankle repair performed by respondent, wound and bony debridement, antibiotic management and further reconstructive work. Dr. Kopp referred Patient A to his primary care physician for a pre-operative medical clearance so that the surgery could be performed.

15. Medical records from August 18, 2015, show that Patient A was seen by his primary care physician Dr. Lenzkes of Internal Medicine Associates Medical Group of San Diego, Inc. for a pre-operative evaluation. Dr. Lenzkes wrote in his progress note, in part, as follows:

> Presenting Here [*sic*] for preoperative evaluation prior to surgical intervention on left lower extremity for osteomyelitis/cellulitis/nonhealing compound fracture.

Dr. Lenzkes provided medical clearance for Patient A to undergo the surgery recommended by Dr. Kopp.

16. Patient A was seen at the Emergency Department of Scripps Health Mercy Hospital on August 21, 2015, where he was admitted into the hospital for the hardware removal surgery with debridement and infection management by Dr. Kopp. Patient A underwent that surgery on August 21, 2015, and he was thereafter discharged from the hospital on August 26, 2015. A pathology report from examination of specimens taken from Patient A's ankle and fibula during the August 21, 2015, surgery show that Patient A had acute and chronic osteomyelitis in the left fibula and left ankle.

17. On August 21, 2015, after his surgery on August 21, 2015, Patient A was seen by Nancy Crum-Cianflone, M.D., an infectious disease specialist, by referral from Dr. Kopp for infection and antibiotic management.

18. Medical records indicate that Patient A also underwent further surgeries by Dr. Kopp on November 20, 2015, for repair of his ankle fracture after management of his infections. Medical records from Dr. Kopp dated May 4, 2017, show that Patient A had eventually recovered from his infections and surgeries and his ankle had been healed after the subsequent surgeries and infection management.

Patient A's Deposition Testimony

19. Patient A testified under oath on February 20, 2017, regarding his treatment by respondent as part of a civil lawsuit brought against respondent for the treatment of Patient A. The deposition transcript from Patient A's testimony was received in evidence. The following factual findings are based upon that deposition testimony.

20. Patient A testified that after his initial surgery to repair his ankle performed by respondent at Sharp Memorial Hospital in December 2014, Patient A did not recall any other conversations or discussion from respondent regarding the need for any follow-up or additional surgery.

21. Patient A also testified during his deposition that he mentioned to respondent a few visits after his surgery in December 2014 that he was having "a lot of drainage" from the wound site. Patient A stated that the drainage on the bandages after his surgery had gotten bigger since his surgery. Patient A stated that about one month or one month-and-a-half after his December 2014 surgery his bandages started getting soaked through with drainage and the drainage had increased. Patient A also

stated that the drainage from his wound continually got worse on both incisions on both sides of his foot since the surgery and during the time he had follow-up visits with respondent.

22. Patient A stated that at about one month or one-and-a-half months after his December 2014 surgery, the drainage from his wound changed color from brownish to yellowish/greenish. According to Patient A respondent inspected his wounds after Patient A's complaints of drainage and simply told Patient A that the drainage was normal. Patient A also testified that respondent told him in about March or April of 2015 to "jump in the pool and it would clean it up" because of chlorine. Patient A then testified that during the time he was seeing respondent for follow-up visits after the December 2014 surgery, there were times when one of his two incisions would stop draining, but that incision would resume draining again, and this cycle repeated multiple times. Patient A stated that during the time one incision would stop draining, the other incision would continue to drain. According to Patient A during the time he was seeing respondent for follow-up visits, at least one of his incisions was draining and his drainage continued to soak through the bandages. Patient A testified that on his last follow-up visit to respondent in May 2015, his wounds were still draining such that the drainage was soaking through the bandages.

Expert Testimony Regarding the Treatment and Care of Patient A

TESTIMONY OF GEOFFREY M. MILLER, M.D.

23. Dr. Geoffrey Miller testified as an expert on behalf of complainant at the hearing. Dr. Miller has been licensed to practice medicine in California since 1981. Dr. Miller obtained his medical degree in 1976 from the University of Texas. He completed a general surgery residency in 1978 at New York University and an orthopedic surgery

residency in 1981 at Presbyterian Medical Center in New York. Dr. Miller completed a pediatric orthopedic and rehabilitation fellowship in 1982 at University of Southern California (USC) Medical Center. Dr. Miller is currently employed as a professor and attending physician in orthopedic surgery at USC at Rancho Los Amigos Hospital. Dr. Miller also currently has his own private practice in orthopedics specializing in workers' compensation cases. Dr. Miller currently sees approximately 30 to 100 patients per week at USC and about 20 to 30 patients per week at his private practice. He performs orthopedic surgery about two days per month, supervises orthopedic surgery residents on a weekly basis, and supervises one or more orthopedic clinics weekly. Dr. Miller reviewed Patient A's medical records, the board's investigative report, and deposition transcripts of respondent and Patient A. Dr. Miller summarized his findings in a report received into evidence. The following factual findings are based on Dr. Miller's testimony and related documents received in evidence.

24. Dr. Miller testified that Patient A sustained an open fracture of the tibia with dislocation of his ankle and displacement of the ankle joint on December 27, 2014, which Dr. Miller stated presented a high risk for infection and future surgery. Dr. Miller explained that an open fracture meant that Patient A's tibia was broken, coming through the skin, and sticking out of his body. Respondent performed surgery to repair Patient A's ankle and tibia on December 28, 2014. Dr. Miller noted that respondent gave Patient A antibiotics prior to the surgery and for three days, which Dr. Miller stated was "fair and appropriate." Dr. Miller stated that the "seminal issue" in this case revolved around post-surgery drainage around the surgical site where respondent performed the surgery and acknowledged that respondent and Patient A provided different versions of the description and duration of that drainage. Dr. Miller noted that Patient A stated in his deposition testimony that the wound had continuous drainage from the date of surgery up to the subsequent surgery in August 2015.

However, respondent's deposition testimony indicated that the wound had stopped draining and was healing, but had slight drainage again, which respondent stated was from a stitch abscess.

25. Dr. Miller explained that the surgery performed on Patient A by respondent in December 2014 did not involve sutures and instead the wound was closed by staples, which were taken out two weeks after surgery. He stated, "You would not have a stitch abscess in this case because there were only staples." Dr. Miller acknowledged that in the underlying tissue under the wound, respondent used resorbable sutures, which dissolve in the body after four to six weeks after which the sutures no longer exist. Dr. Miller stated that there are times when the body rejects the resorbable sutures and they rise to the surface of the skin causing a stitch abscess, which is a common and singular event that usually happens the first few weeks following surgery because after about a month those sutures no longer exist. He stated that stitch abscesses typically occur in one or two stitches but not the entire wound. Dr. Miller also opined that because the drainage from the wound was both in the medial and lateral aspects of the wound, as admitted by respondent during his deposition, and persisted for more than a few weeks, then it is not possible for the drainage to be caused by a stitch abscess, but rather it must be caused by an underlying infection.

26. Dr. Miller testified that on the first follow-up appointment on January 12, 2015, with respondent after his surgery, Patient A was complaining about "surgery drainage." Dr. Miller noted that this was about 12 days after the surgery and would be a concern for most doctors who would be suspicious of an underlying infection causing that drainage, particularly given that Patient A is high risk for infection because of the nature of his underlying injury. However, Dr. Miller noted that

respondent's failure to get an X-ray, get a culture of the drainage, or otherwise rule out an infection did not constitute a deviation from the standard of care at this point in time. Dr. Miller opined that the standard of care is what other comparably trained physicians would reasonably do under similar circumstances.

27. Dr. Miller noted that on the second follow-up appointment on January 19, 2015, with respondent after his surgery, Patient A was still complaining about "surgery drainage." Dr. Miller testified that this was beyond 12 days after the surgery and most doctors would be suspicious of an underlying infection causing that drainage and would get an X-ray, culture of the drainage, maybe restart antibiotics, and at least watch the wound weekly to ascertain its progression, but respondent did none of those things. Dr. Miller opined that respondent's failure to do those things constituted a deviation from the standard of care, which he characterized as an extreme departure from the standard of care. Dr. Miller also noted that on the January 19, 2015, visit, respondent ordered six weeks of wound care with dressing changes twice a day for Patient A, an order that Dr. Miller stated would be inconsistent with a stitch abscess and more consistent with a situation where Patient A had significant drainage.

28. Dr. Miller testified that respondent's actions, or inactions, at each visit after the January 19, 2015, visit, constituted a simple departure from the standard of care because respondent failed to obtain a lab test to assess whether Patient A had an underlying infection. Dr. Miller testified that these simple departures from the standard of care for each visit constitute a separate departure than the one extreme departure from the standard of care respondent committed for his failure to order any labs or cultures for Patient A generally after the 12 days post-surgery when Patient A exhibited drainage, redness, and pain when Patient A was high risk for infection.

29. Dr. Miller testified that on Patient A's visit to respondent on February 23, 2015, respondent committed a departure from the standard of care in his treatment of Patient A which he characterized as an extreme departure. Specifically, on February 23, 2015, respondent obtained an X-ray of Patient A showing that there was "a fracture angulation and displacement," which is abnormal. Dr. Miller opined that any displacement of a fracture that was previously fixed by surgery suggests that there is an infection causing the screws to loosen in the hardware or some other problem with the repair. Additionally, Dr. Miller stated that according to Patient A's deposition testimony, there was still drainage from the wound at this point, which is another indication of infection. Respondent's medical records for this February 23, 2015, visit provided no information regarding if and to what extent Patient A had drainage and provided no information regarding any follow-up by respondent regarding the abnormal X-ray. Dr. Miller opined that respondent's failure to follow-up on the abnormal X-ray by obtaining lab results from blood, taking a culture of the discharge, or ruling out an infection, was an extreme departure from the standard of care. Dr. Miller also noted that in his deposition testimony respondent stated that X-rays do not show infection. However, Dr. Miller stated that respondent's assertion is simply incorrect and that X-rays can show signs of infection in a patient.

30. Dr. Miller also opined that Patient A complained of drainage from the wound in May 2015, months after the surgery, but respondent had still not ruled out an underlying infection, but instead noted in the patient records that Patient A had a "stitch abscess." Dr. Miller stated that for Patient A to continue to have drainage from the wound by this date indicated he had an infection and respondent failed to take any steps to assess the underlying cause of the drainage. On Patient A's last visit with respondent on May 27, 2015, Patient A continued to have drainage in his wound and respondent noted in the patient records "minimal drainage." Dr. Miller stated that any

drainage that is five months after surgery is a serious concern that would indicate an underlying infection. Dr. Miller opined that respondent's failure to recognize this fact shows he was incompetent and lacked basic knowledge to recognize the signs of infection. Additionally, on this visit respondent did nothing to assess the underlying cause of the drainage, which Dr. Miller stated was an extreme departure from the standard of care.

31. Furthermore, Dr. Miller was most concerned by the fact that respondent set the next follow-up appointment for Patient A to occur in September, four months later, without any assessment of the cause of the drainage, which in his view was an extreme departure from the standard of care. Dr. Miller explained that respondent's failure to follow-up with Patient A for four months was "mindboggling" considering Patient A continued to have discharge indicating he had an underlying infection. He further explained that the underlying infection would only get worse with time without treatment and progress to infecting the bone, which is exactly what occurred in this case. The passage of time without treatment or assessment enabled the infection to progress to the point where it could not easily be dealt with later. Dr. Miller characterized respondent's failure to rule out infection and to fail to get any follow-up with the patient for four months as an extreme departure from the standard of care.

32. Dr. Miller also noted that with regard to the May 27, 2015, visit, respondent wrote that Patient A had an "insensate foot," which Dr. Miller stated means that the patient is losing feeling in the foot and could indicate that an infection involving the nerves of the foot or some other cause is affecting the nerves of the foot. Dr. Miller opined that respondent's failure to follow-up on the insensate foot was a simple departure from the standard of care because Dr. Miller had insufficient records to make any determination regarding the specifics of the "insensate foot" issue.

33. Dr. Miller also opined that respondent's recordkeeping for Patient A constituted a simple departure from the standard of care. Dr. Miller noted that respondent's medical records for Patient A did not provide any detail with regard to what was happening with Patient A, such as discussion about the amount and nature of the drainage from the wound, no future plans for treatments, no mention of discussions with the patient about future surgeries. Respondent's records were incomplete and extremely brief and lacked any detailed discussion of the state of the patient and care provided. Dr. Miller explained that patient records are essential to provide continuity of care from one provider to another so that the next care provider can determine from the records the progression of the patient's condition and treatment provided in order to provide appropriate care moving forward. According to Dr. Miller, Patient A's medical records from respondent were so inadequate that it was not possible to determine exactly what happened with Patient A.

34. Dr. Miller noted that there was no indication in respondent's patient records for Patient A that respondent ever discussed with Patient A the need for future surgery other than a note in the discharge summary from December 2014 that he may need a future washout surgery. He stated a basic premise in medicine is that if it is not documented it did not happen. Dr. Miller further noted that Patient A's ankle fracture was of the nature that it would likely require more than one surgery, specifically a fusion surgery in order to treat chronic pain in the ankle joint. However, because Patient A suffered from infections in his bones he ultimately had a tibio-talo-calcaneal (TTC) fusion surgery in November 2015, which was a surgery required because of the infection and not because of his injury in December 2014. Ultimately, Patient A had three additional surgeries, the first in August 2015 to remove the hardware from the surgery respondent performed and to clean the wound, the second surgery was to remove part of the tibia, fibula, and talus that had become infected and needed to be

removed as a result, and the third surgery was the TTC fusion surgery, which occurred in November 2015. Dr. Miller opined that respondent's failure to document any discussion with Patient A regarding the need for any future surgeries was a simple departure from the standard of care.

35. On cross-examination Dr. Miller stated that it was his assessment that Patient A experienced continued drainage from the surgical wound created by respondent in December 2014 up to the date of Patient A's last visit with respondent on May 27, 2015. Dr. Miller stated that the basis for this assessment was Patient A's testimony during his deposition and the limited information in the medical records. Dr. Miller acknowledged there were patient records from respondent that indicated there was no drainage on February 23, 2015, and another that the wound had closed, but there was also notes that drainage continued even until May 27, 2015, which are inconsistent and make no sense. Dr. Miller again emphasized that a stitch abscess cannot continue for months and respondent's continued insistence that Patient A's drainage during the visits was due to a stitch abscess was wrong and there is no basis for a wound to be open for three months.

36. Also, on cross-examination Dr. Miller acknowledged that he reviewed the labs taken in August 2015 at the time Patient A had his initial follow-up surgery. Dr. Miller stated that the culture of the drainage at that time showed infection, but he could not recall if the blood results showed elevated white blood cell count (WBC), which would also indicate infection. Dr. Miller stated that if the WBC was normal in August 2015, that could be because Patient A's immune response was muted, but regardless, Patient A had a significant bone infection at that time.

37. On cross-examination Dr. Miller also stated that he has no idea if Patient A returned to work because that information was not in the patient records.

TESTIMONY OF ANTHONY SANZONE, M.D.

38. Dr. Anthony Sanzone testified as an expert on behalf of respondent at the hearing. Dr. Sanzone has been licensed to practice medicine in California since 1999. He obtained his medical degree in June 1991 from Loyola University of Chicago. He completed a residency in general surgery in 1993 at the Chicago Medical School, and he completed an orthopedic surgery residency in 1998 at Boston University Medical Center. Dr. Sanzone completed a fellowship in orthopedic traumatology in 1999 at the University of Washington Harborview Medical Center in Seattle. Dr. Sanzone has worked in private practice since 1999 as an orthopedic traumatologist, which is the care of patients with traumatic injury to their long bones. About 95 percent of Dr. Sanzone's practice involves bone fracture care. Dr. Sanzone has cared for one to two open fracture patients per month for the last 10 years.

Dr. Sanzone reviewed Patient A's medical records, Dr. Miller's report, the deposition transcript of respondent, and the accusation in this matter. Additionally, Dr. Sanzone met with respondent in person to discuss respondent's recollection of his treatment of Patient A. Dr. Sanzone testified that his in-person meeting with respondent to discuss the care of Patient A was helpful to him "to better understand what happened." Dr. Sanzone summarized his findings based on his review of the medical records and his discussion with respondent in a report received into evidence. The following factual findings are based on Dr. Sanzone's testimony and related documents received in evidence.

39. Dr. Sanzone testified that Patient A, who had a history of smoking, suffered an open fracture of his ankle in December 2014, which by its nature indicated that there was a high probability that Patient A would ultimately have to have a fusion surgery at a later time after the repair surgery completed by respondent. Patient A's

injury had an extrusion of the tibia through the open wound prior to the December 28, 2014, surgery by respondent. Dr. Sanzone testified that after his review of the medical records and discussion with respondent regarding respondent's care of Patient A, he concluded that respondent's care of Patient A did not deviate from the standard of care. Dr. Sanzone testified that he understands that the standard of care means what a reasonably careful physician would do under similar circumstances.

40. Dr. Sanzone opined that respondent's care of Patient A after the December 28, 2014, surgery did not depart from the standard of care because respondent "closely monitored" Patient A by seeing him four times in the first eight weeks after the surgery. Dr. Sanzone testified and wrote in his report that Patient A was a 67 year-old smoker, and smoking can cause prolonged healing times and associated "wound problems" because smokers typically have diminished blood flow due to hardening of the arteries. On the first follow-up visit after surgery on January 12, 2015, Dr. Sanzone noted that respondent's records did not show that there was any significant drainage in the area of the wound, but that the patient had a blister in the area of the wound, which Dr. Sanzone stated was normal. In his report, Dr. Sanzone characterized the blister as a "fracture blister noted medially which is where the bone had extruded through the skin."

41. On Patient A's second follow-up visit to respondent on January 19, 2015, respondent's medical records reflect that there is some drainage from the surgical wound. Dr. Sanzone noted that respondent's records state that there was no erythema, meaning redness, that would indicate an infection. Dr. Sanzone stated that having drainage at this point post-surgery is normal, particularly in a patient who is a smoker and with an open fracture. Dr. Sanzone opined that those types of wounds, particularly in a smoker, "never look good" and have difficulty healing. Dr. Sanzone would not

have taken a culture of the drainage on January 19, 2015. He also noted that respondent ordered home health care to change Patient A's dressing twice a day, which Dr. Sanzone characterized as "being careful" so that the patient did not have to change the dressings himself.

42. Dr. Sanzone stated that the next visit by Patient A to respondent was on February 9, 2015, which was three weeks after his last visit and a reasonable amount of time for follow-up. According to Dr. Sanzone, there was no reason for respondent to be concerned about infection on this visit because the patient was improving. However, Dr. Sanzone qualified this opinion by stating, "by what I am seeing in [respondent's] records." Dr. Sanzone stated that the standard of care would not require respondent to culture the wound drainage on this visit. In his report Dr. Sanzone wrote regarding this visit that:

> [T]he medial wound demonstrated a 2-mm wound along the medial aspect according to Dr. Chadha's notes and recollection, there was no evidence of erythema or fluctuance around the incision and the wound was healing.

However, it is noted that the medical records for respondent for the February 9, 2015, visit provide no information regarding erythema or fluctuance around the incision or that the wound was healing.

43. Dr. Sanzone testified that the next visit was about two weeks later on February 23, 2015, which was a reasonable time for follow-up with Patient A. Dr. Sanzone noted that Patient A stated he was improving on the patient intake form, but Dr. Sanzone made no mention of the fact that on the same form the patient complained of "drainage on leg." Dr. Sanzone's reading of respondent's notes for this

visit was that Patient A had no drainage but did have edema, which is swelling. He explained that patients can have swelling up to a year after surgery normally. Dr. Sanzone stated that "based on this [respondent's] note" it seems Patient A was healing. Dr. Sanzone also stated that respondent took an X-ray of Patient A's ankle on this visit and the records for the X-ray have some boxes checked, specifically, a box with the letters "WNL," which Dr. Sanzone stated he did not know what those letters meant, and a box next to the words "implants/hardware intact." Dr. Sanzone stated that he thinks that the form regarding the X-ray was ambiguous but that he has to assume that means the fracture is healing. Dr. Sanzone acknowledged on cross-examination that the standard of care would require that respondent state explicitly that the wound had not yet healed, which respondent did not do. In his report regarding the February 23, 2015, visit Dr. Sanzone wrote, in part:

> [T]he patient was re-evaluated and the wound was healed. In addition, the patient was able to move his ankle with only some minor pain. Radiographs demonstrated callus formation and the patients range of motion was improving. Radiographs did demonstrate significant narrowing of the joint space consistent with early post-traumatic arthritis. The patient was then, according to [respondent], advised that he is most likely developing post-traumatic arthritis and would likely require a fusion at a later date.

Notably, respondent's medical records for this February 23, 2015, visit did not provide that Patient A's wound had healed, did not provide any information regarding Patient A's ability to move his ankle with or without pain and did not contain any information

regarding respondent's advising Patient A that a fusion surgery would be likely be required at a later date.

44. The next follow-up visit for Patient A with respondent was 10 weeks later on May 13, 2015. Dr. Sanzone opined that was an appropriate amount of time and a "personal preference." Dr. Sanzone noted that he "probably would have seen the patient in about eight to ten weeks after the last visit." Dr. Sanzone testified that at this visit respondent "was probably trying to get an x-ray at that time." However, nothing in the medical records indicates that respondent got, or attempted to get, an X-ray of Patient A on May 13, 2015. Dr. Sanzone acknowledged that the patient's chief complaint on his intake form was "drainage on leg," but stressed that the patient also indicated in the checked box that he was getting better. Based exclusively on respondent's notes in the medical record, Dr. Sanzone stated that respondent found "small stitch abscesses," one on the medial side and one on the lateral side of the wound. Dr. Sanzone explained that a stitch abscess is a "pinpoint area where the body spits the suture out" which can "cause a little bit of drainage." Dr. Sanzone stated that he has seen stitch abscesses happen this late after a surgery, but it is not common. Dr. Sanzone stressed that he did not see this wound on May 13, 2015, and as a result, he did not make his own assessment of whether it was reasonable to interpret the drainage happening on the patient's wound to be caused by a stitch abscess or something else. Dr. Sanzone stated, "I am going on what [respondent] said in his notes," but admitted that those notes were "not detailed" and did not provide whether Patient A had erythema around the wound. In his report Dr. Sanzone wrote:

> At that visit, it should be noted that Dr. Chadha's [*sic*] recalled that there was no warmth, erythema, or fluctuance

in the area, and the patient had good range of motion in his ankle.

Notably, the medical records from May 13, 2015, provide no information regarding whether Patient A had warmth, erythema, or fluctuance in the area of his wound and no information regarding Patient A's range of motion in his ankle.

45. Patient A's next and last visit to respondent was on May 27, 2015, two weeks later. Dr. Sanzone noted that the patient intake form for this visit indicated that Patient A was getting better and did not mention any drainage. Dr. Sanzone stated that respondent made a note in the medical record of "minimal drainage" and Dr. Sanzone acknowledged he did not know what that meant because that "is a subjective thing when you look at the wound." Dr. Sanzone stated "there is nothing in the [medical] records to indicate this is a red flag or that alarms should be going off" to indicate an infection. Dr. Sanzone also stated that respondent took an X-ray of Patient A's ankle on that visit. Dr. Sanzone admitted he could not tell anything from those X-ray results other than the implant and hardware were within normal limits. He admitted that respondent also wrote in the medical record "insensate foot," and Dr. Sanzone "is not sure what he means by that." Dr. Sanzone explained that insensate food could mean that the patient had lost feeling in the foot due to compromise of his nerve in the ankle, which can happen from trauma but does not happen from infection. He further explained that the "insensate foot" would not be cause for alarm because there is no repair for it and you simply wait to see if it heals on its own, which is within the standard of care.

Dr. Sanzone also stated that with regard to the last visit on May 27, 2015, that respondent handled that visit within the standard of care, and that a follow-up appointment in four months was appropriate. Specifically, based on discussions with

respondent, Dr. Sanzone understands that respondent discussed with Patient A on this visit that a future surgery of a fusion would be necessary, but because Patient A was an HMO patient, respondent would not be able to perform that fusion surgery because of insurance constraints. As a result, respondent had to involve Patient A's primary care physician for authorization of any further procedures. Respondent was in contact with Patient A's primary care physician so that Patient A could see another orthopedic surgeon who was in Patient A's insurance plan. According to what respondent told Dr. Sanzone, Patient A was reluctant to schedule an additional surgery.

46. On cross-examination, Dr. Sanzone acknowledged that if on May 13, 2015, or May 27, 2015, that the patient's wound had not healed and was still draining or getting red or hurting, then Dr. Sanzone would be concerned about infection, especially in a smoker. However, based exclusively on respondent's medical records, he understands that the wound had healed or was getting better and then on May 13, 2015, Patient A had only two stitch abscesses, which respondent treated appropriately by draining them and evaluating Patient A again in two weeks. Dr. Sanzone acknowledged that Patient A complained of "drainage on the leg" on May 13, 2015, but noted that Patient A's record does not state how much or frequently the drainage occurred. Dr. Sanzone agreed that respondent's characterization of the drainage from Patient A's wound on May 27, 2015, as "minimal drainage" was ambiguous.

47. Dr. Sanzone acknowledged that based on his review of medical records from August 2015, Patient A had an infection in the wound at that time. Dr. Sanzone noted that Dr. Fabi's report from August 2015 shows that Patient A had some drainage and some poor healing wounds in the ankle area. However, Dr. Sanzone noted the medical records did not show a swollen, red ankle with puss, but instead "just had small areas of drainage." Dr. Sanzone stated that the medical records, lab work results

and cultures taken of Patient A's drainage were not consistent with the idea that Patient A had an undiagnosed infection since the time he last saw respondent. Specifically, the CT and MRI studies taken in August 2015 do not show large fluid collections in both the medial and lateral gutters and fluctuance and/or sinus tracts overlying the open wounds and therefore those studies do not show severe infection. Dr. Sanzone opined that he believes that Patient A had a slow infection that finally manifested three months after he last saw respondent. In his report Dr. Sanzone wrote:

> The patient potentially could have developed an infection over this time which was subclinical or indolent when [respondent] saw the patient and then began to increase in severity.....This was potentially a very indolent, slow, manifesting osteomyelitis in his ankle which I believe became significant in August when he was seen initially by Dr. Fabi.
>
> From my review of the material in this complex case, I do not see evidence that [respondent] is incompetent or acted incompetently with this patient. Overall, the patient's condition was not worsened due to a negligent care by [respondent]. Finally, I do not feel that any gross negligence or negligence by [respondent] was performed and hence, no reason to restrict [respondent's] license.

48. Dr. Sanzone opined that if Patient A had an infection in his ankle in April or February of 2015 that went untreated until August 2015, he would expect that Patient A would have a much more severe outcome and would not be able to walk on

his leg. However, Patient A returned to work in May 2015, which Dr. Sanzone said would be unusual if Patient A had an infection because it would hurt.

The Board's Attempts to Interview Respondent

49. Sarah Peters is a Special Investigator for the board, a position she has held since June 2014. She has undergone multiple training courses related to her position during the course of her employment. Ms. Peter's duties in her position include investigation of physicians related to possible disciplinary actions brought by the board. Since she took her current position, Ms. Peters has investigated approximately 410 cases of possible physician disciplinary action, and of those about 100 have been prosecuted by the Attorney General's in disciplinary actions. The remaining cases were closed after her investigation. Ms. Peters investigated respondent as related to this matter and summarized her findings in a report, which was received in evidence. Ms. Peters testified at the hearing and the following factual findings are based on her testimony and related documents received into evidence.

50. Ms. Peters was assigned to investigate respondent in April 2019 after the board received "an 801 report" from an insurance company on December 21, 2017. Ms. Peters explained that insurance companies have a mandatory reporting requirement to the board when there is a settlement in a civil malpractice lawsuit in an amount more than $30,000. The insurance companies utilize the 801 report to report those settlements and also provide uncertified copies of related medical records. In this case the board received an 801 report regarding a settlement in a civil malpractice lawsuit against respondent regarding Patient A. Ms. Peters was assigned to investigate this matter on April 23, 2019, after receiving the 801 report and related documents.

51. After the 801 report was received by the board and prior to the assignment of this matter to Ms. Peters, the board reached out to respondent on May 14, 2018, to obtain a summary of care for Patient A and respondent's Curriculum Vitae. Additionally, the board reached out on May 14, 2018, and again on September 24, 2018, and October 30, 2018, to attorneys in the civil lawsuit against respondent to obtain deposition transcripts and medical records. The defense attorneys from the civil lawsuit provided the requested documents in September 2018. Ms. Peters sent a fourth request for those documents to the plaintiff's attorneys by email on June 25, 2019. On May 14, 2018, the board also reached out to Patient A to obtain a release for medical records related to the matter. Ms. Peters collected the requested documents and continued to obtain required medical release form signatures from Patient A as needed.

52. On June 25, 2019, Ms. Peters requested medical records from respondent's medical office, Synergy Orthopedic Specialists (Synergy), for Patient A. On June 25, 2019, Synergy replied to the request with a certification that they had no such records. On December 17, 2019, Ms. Peters sent a second request for medical records regarding Patient A to Synergy. Synergy responded to that request on January 3, 2020, with the requested medical records.

53. Ms. Peters first reached out to respondent's office to request an interview of respondent on February 12, 2020. In response to this request, Ms. Peters received a voicemail from respondent later in the day on February 12, 2020, instructing her to contact respondent's office manager, Tom Reardon, to set up the interview and providing her with Mr. Reardon's contact information. On February 13, 2020, Ms. Peters called Mr. Reardon and attempted to leave a voicemail, but his voicemail box was full. Ms. Peters then called the receptionist at Synergy on February 13, 2020, and

instructed her to give her contact information to Mr. Reardon and ask him to call her. Mr. Reardon responded to Ms. Peters by email on February 13, 2020, telling her that he would check with respondent regarding his availability for an interview and get back to her with some dates. Ms. Peters emailed Mr. Reardon on February 23, 2020, again asking for some dates for an interview of respondent, and she noted that she would prefer that he get back to her prior to February 28, 2020, because Ms. Peters would be on maternity leave after that date. Ms. Peters testified that Mr. Reardon did provide some dates for respondent's interview, and Ms. Peters provided those dates to her supervisor, Rashya Henderson, so that Ms. Henderson could conduct the interview during Ms. Peters' maternity leave. Ms. Peters was on maternity leave from March 3, 2020, to June 18, 2020.

54. On March 11, 2020, Ms. Henderson sent an email to Mr. Reardon asking to interview respondent on April 7, 2020, at 11:30 a.m. or another time of his preference. Ms. Henderson did not receive a response to this email from respondent or Mr. Reardon.

55. Ms. Peters again reached out to respondent's office on June 12, 2020, prior to her return from maternity leave, to follow up on respondent's availability for an interview because the interview did not happen during her maternity leave. Ms. Peters did not receive a response to this request. On June 26, 2020, Ms. Peters emailed respondent directly and informed him that Mr. Reardon has not responded to her recent phone calls or emails and she needs to schedule an interview with respondent. Ms. Peters did not initially hear back from respondent after sending this email. Finally, on July 31, 2020, Ms. Peters had a telephone call with both Mr. Reardon and respondent where she informed them that this matter had been submitted to an expert reviewer for the board and Ms. Peters mentioned the possibility of having

respondent submit a letter of explanation regarding his care of Patient A in lieu of an interview in light of the COVID-19 pandemic. During that July 31, 2020, telephone call respondent asked what questions he needed to answer in the letter of explanation and Ms. Peters stated she would get that information from the expert reviewer. However, Dr. Miller (complainant's expert) informed Ms. Peters that an interview would be necessary rather than a letter of explanation.

56. On July 9, 2020, Ms. Peters sent a formal interview request by certified mail to respondent. However, she did not get a response from respondent regarding this request. Ms. Peters submitted this matter to the Attorney General's office at the end of August 2020 and still had not yet heard back from respondent regarding the interview request.

57. Ms. Peters testified that she did not issue a subpoena to obtain respondent's interview because during the 2020 time period she was requesting an interview of respondent, all interviews were being conducted by telephone and Microsoft Teams because of the COVID-19 pandemic, and she was unsure if she could subpoena such a telephonic/videoconference interview.

58. Ms. Peters reached out to Mr. Reardon a total of nine times attempting to schedule an interview with respondent. She reached out to respondent a total of three times to set up the interview.

Respondent's Testimony

59. Respondent is 57 years old and in private practice in orthopedic surgery at Synergy, which is a large medical group comprising five or six different private practices providing orthopedic care. Respondent has his own private practice called Lenihan, Selecky, Chadha Orthopaedics, Inc., which is part of Synergy. He has had his

own private practice since 2002 and that private practice has been a part of Synergy since 2012. Respondent's practice focuses on adult reconstruction involving joint replacement and trauma. Respondent explained that trauma care in San Diego County has different levels of care. Specifically, level two trauma care involves more complex injuries than does a level three trauma care. Respondent accepts mostly complex trauma injures at a level two, which he has been designated to do since 1999. Respondent took the lead at Sharp Memorial Hospital to advance that facility from a level three trauma center to a level two trauma center in 1999. He has worked as the Chief of Surgery at Sharp Memorial Hospital Chula Vista from January 2020 to present. He is affiliated with Sharp Memorial Hospital at various of its locations, Scripps Mercy Hospital, Paradise Valley Hospital and Alvarado Hospital.

60. Prior to his treatment of Patient A in December 2014, respondent had treated approximately 200 to 300 patients with similar types of ankle fractures. Respondent currently sees a patient with the same severity of ankle fracture as that of Patient A about once or twice per month.

61. Respondent described the surgery he conducted on Patient A on December 28, 2014, as routine but that the injury was severe because it was a complicated ankle fracture. During the time Patient A was in the hospital in December 2014, respondent discussed with Patient A the extent of his injury and the need for future surgery because he had a significant amount of cartilage damage, a lot of broken bones, and a large laceration where the bone had come through the skin. Respondent stated that the future surgery he discussed with Patient A was foot and ankle surgery with a possible cartilage transplant or a fusion. He claimed he had this conversation with Patient A at every visit, and Patient A acknowledged that he understood he needed a future surgery but was not ready to have it. Respondent

stated that about 88 percent of patients with the same injury as Patient A ultimately require a fusion surgery because of pain. However, the fusion surgery will sacrifice the range of motion in the ankle and accordingly the patient must be motivated by pain to agree to the fusion surgery. Respondent stated that the medical records from the December 2014 surgery, including the discharge notes, provide that respondent discussed the possible need for future surgery with Patient A. Respondent claims that he continued to have those same discussions with Patient A during the post-operative visits, but admits he did not record those discussions in his medical records.

62. Based on the nature of Patient A's injury, respondent administered intravenous antibiotics to him for three days while he was in the hospital to prevent infection. After Patient A was discharged from the hospital in December 2014, respondent prescribed oral antibiotics of 500 mg of Keflex twice a day for two weeks.

63. Respondent discussed his post-operative care of Patient A, primarily at the May 2015 visits. During the May 13, 2015, visit respondent diagnosed Patient A with two stitch abscesses, one medial and one lateral of the wound, both of which were not previously present. Respondent explained that a stitch abscess is a lesion usually the size of a pinpoint that "when expressed has very little drainage." He stated that to "express" the lesion you simply squeeze it like a pimple and that a stitch abscess usually has the same appearance as a pimple. Respondent explained that stitch abscesses are caused by resorbable sutures deep in the tissue. Respondent stated that the resorbable suture is the type of suture recommended for ankle surgery, and stitch abscesses occur with those sutures, although it is more infrequent than frequent that stitch abscesses occur. Prior to May 2015 respondent would see stitch abscesses on a patient's ankle about once every two weeks. On May 13, 2015, respondent made the determination that Patient A had two stitch abscesses because

there was no swelling, no redness, no pain or tenderness to the touch and the lesions were small. Respondent treated the stitch abscesses by removing the stitch from the wound area and expressing "a tad of fluid."

64. On May 27, 2015, respondent noted that Patient A had "minimal drainage," which respondent testified was "very little drainage." Respondent stated that the drainage on that date "was decreasing over time because it was a stitch abscess." He also stated that Patient A had good movement of his ankle with not much stiffness when he walked, and his strength was four out of five. Respondent noted that if Patient A had an infection of the wound there would have been more drainage, redness, tenderness, and even hardening of the skin around the wound, but respondent saw none of that.

65. Respondent disagreed with Dr. Miller's assertion that Patient A had an ongoing infection that persisted post-operatively because in order for that to be the case, the drainage must be persistent and not "start and stop" like it did with Patient A. Respondent also stated that the stitch abscesses were located where he put the deeper stitches and not in the location where the bone pushed through the skin where you can have cellulitis or marginal necrosis. Respondent also stated that if Patient A had an untreated wound infection in May 2015, he would not be ambulating as he was and would have more manifestations of the infection like redness, tenderness, and swelling. Respondent acknowledged that he and Patient A disagree regarding the amount of drainage from the wound. Specifically, Patient A testified in his deposition that there was a lot of drainage and it was continuous. Respondent contends that there was "not much drainage" and that the drainage was intermittent.

66. On the May 27, 2015, visit respondent also wrote "insensate foot" in the medical records. He explained that insensate foot means that the patient has a sensory

deficit to light touch as a result of an injured nerve. He explained that the motor portion of the nerve still works. Respondent stated that insensate foot also encompasses both "light touch" and "deep touch" nerve injury, and in deep touch injury the patient may develop ulcers of the foot. Regardless, with insensate foot you do not know if the nerve will recover over time, and insensate foot is not caused by infection and is instead, caused by the original traumatic injury. Respondent testified that the insensate foot issue did not require any follow-up because the only assessment studies available are to evaluate motor injuries to nerves, which Patient A did not have because he was walking. The insensate foot may get better over time, or it may not.

67. Respondent explained his reasoning for having a four-month follow-up appointment after the last May 27, 2015, visit. Specifically, Patient A had returned to light duty at work already as a teacher and was functioning in the classroom. Respondent decided the wound was "healed enough" so that Patient A could tolerate another surgery and recommended that respondent have the fusion surgery, which would require a foot and ankle specialist. However, because Patient A was in an HMO and respondent was not part of that insurance plan, Patient A had to go to his primary care provider to initiate that process. On May 27, 2015, Patient A was not ready to sacrifice his range of motion in the ankle for the fusion surgery in order to get rid of the pain. Respondent stated that he wanted to give Patient A time to "get to that next decision and embrace it." Respondent stated that he recommended Patient A see his primary care physician, but if he could not get that done then respondent would see him in four months. The four-month follow-up visit was a "fall-back" in case Patient A was not able to or did not see his primary care physician.

68. Respondent also testified that he reviewed the medical records from August 2015 for Patient A, including the lab studies to determine if Patient A had an infection. He noted that the WBC count, temperature, C-reactive proteins, and erythrocyte sedimentation rate were all within normal limits. Respondent opined that if Patient A had an infection in his wound "for six to eight months" then those findings would not be within normal limits. Furthermore, respondent opined that the drainage culture results only had incidental findings of bacteria and not "a ton of bacteria." Accordingly, respondent stated that the infection was not extensive or "raging" in August 2015.

69. Respondent admitted during his testimony that his medical records from the post-operative visits of Patient A did not include any information regarding respondent's discussion with Patient A related to the need for future surgery. The only medical records showing that respondent had those discussions with Patient A were in the December 2014 hospital records at the time of surgery. Respondent also admitted that "looking back" he wishes he had more extensive patient charting and notes in his post-operative medical records than what he actually did. He believes he could have done better describing his findings on Patient A in his medical records.

In 2015 respondent's medical office did not use electronic medical records (EMR) and instead used paper forms, which his office still uses today for Medicare compliance purposes. However, his office implemented EMR in 2018 and it generates more extensive notes for the patient's chart and also allows him to attach photographs and X-rays and is generally more comprehensive than the older paper system his office used. Additionally, respondent completed a two-day medical record keeping course from the University of California Irvine in February 2021.

70. With regard to the board's attempts to interview respondent, respondent stated that he never refused to submit to an interview with the board and tried to have Mr. Reardon work with the board to set up a time for the interview. Respondent explained that Mr. Reardon was the office manager for respondent's private practice during the 2020 time period. Respondent put Mr. Reardon in charge of orchestrating the interview with the board because respondent's schedule is unpredictable and he usually would have to project out at least a month to get time for an interview, and also Mr. Reardon is always available whereas respondent may be in the operating room. Respondent testified that at some point Mr. Reardon was terminated from his position as office manager based upon inadequate performance of his job.

Respondent stated that during the July 31, 2020, telephone conference with Ms. Peters and Mr. Reardon, Ms. Peters discussed the possibility of a written summary statement in lieu of an interview, but later in the conversation he was informed he needed to do an interview rather than a written statement. Respondent also recalls that during that telephone call he asked if he could have a lawyer present during the interview. On August 5, 2020, respondent reached out to his insurance carrier, who responded by providing him with legal counsel.

Respondent's Character Witnesses

71. Respondent provided two witnesses to testify regarding respondent's character at the hearing. The first witness was Dr. Michael Bryan Lenihan, respondent's partner for over 15 years in the private orthopedic practice, which is part of Synergy. Dr. Lenihan has known respondent for about 25 years. Dr. Lenihan met respondent at Sharp Memorial Hospital when they both were taking emergency trauma orthopedic surgery calls. Dr. Lenihan, another physician, and respondent decided to open a private practice together. Dr. Lenihan has reviewed many physicians' competency and

character because he has been on the governing board of hospitals, the Synergy group and Chief of Surgery at Sharp Memorial Hospital Chula Vista. Dr. Lenihan has observed respondent operating over the years and characterized him as an excellent physician and has referred family and friends to respondent, especially for joint replacement, which is a subspecialty for respondent. Dr. Lenihan characterized respondent's patient care as excellent and stated respondent has high moral standards. Dr. Lenihan testified that he will need a knee replacement himself in the near future and he expects that respondent will perform that surgery. Dr. Lenihan does not believe that respondent needs any additional training or supervision. Dr. Lenihan also wrote a letter of support regarding respondent that mirrored his testimony and was received in evidence.

72. The second witness was Pablo Velez, who is currently the Chief Executive Officer of Sharp Memorial Hospital Chula Vista, a position he has held for the past 13 years. Mr. Velez has known respondent since 2002 when respondent joined Sharp Memorial Hospital Chula Vista. Mr. Velez has worked with respondent at that hospital since 2002. Mr. Velez stated that respondent is currently the Chief of Surgery at the hospital, a position he has held for the past two years. Respondent was re-elected to the position of Chief of Surgery by the medical staff recently for a second term beginning in January 2022. Mr. Velez testified that respondent stands out amongst surgeons at the hospital as one of the leaders of the community there and has improved the quality of healthcare at the hospital. Mr. Velez also stated that respondent has been a part of the physician advisory committee at the hospital that ensures the care provided meets the standard of care. Mr. Velez has complete confidence in respondent and considers him an excellent physician. Mr. Velez wrote a letter in support of respondent that mirrored his testimony and was received in evidence. Mr. Velez's letter also provided, in part:

> With his experience, surgery complications rates were greatly reduced, as reflected in the national benchmark. [Respondent] has one of the lowest rates of infection in the community, and when compared to the national standard. He helped design a dashboard for the entire Sharp hospital system, to follow surgical complications involving joint replacements and fractures, to improve quality of care.

Summary of the Parties' Arguments

73. Complainant argues that they have presented clear and convincing evidence that respondent made an extreme departure from the standard of care constituting gross negligence by failing to take any steps to rule out an infection in May 2015 during a time Patient A continued to have drainage, and by failing to follow-up with the patient for four months after the May 27, 2015, visit when Patient A still had drainage; that respondent committed repeated negligent acts for each of the visits in May 2013 that respondent failed to take steps to rule out infection; that respondent was incompetent for failing to recognize the signs of infection in Patient A; that respondent made a simple departure from the standard of care for failure to maintain adequate medical records for Patient A and for failing to follow-up on the insensate foot; and that respondent failed to provide an interview with the board without good cause. Complainant recommends respondent's certificate be placed on three years of probation with terms including education course, medical recordkeeping course, professionalism program, ethics course, practice monitor, clinical competence assessment program, and solo practice prohibition.

74. Respondent argues that the complainant has failed to meet its burden to prove by clear and convincing evidence that respondent deviated from the standard of

care for his treatment of Patient A or to prove that respondent was incompetent in his care of Patient A. Respondent further argues that respondent has never refused or failed to provide an interview with the board. Respondent admits that his recordkeeping for Patient A could be better and has taken steps to address this issue by completing a record keeping course and implementing EMR in his practice. Respondent believes that no discipline is warranted, but if discipline is warranted based on the record keeping issues, then a letter of reprimand is appropriate.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. Complainant bears the burden of proof of establishing that the charges in the accusation are true. (Evid. Code, § 115; 500.) The standard of proof required is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The obligation to establish charges by clear and convincing evidence is a heavy burden. It requires a finding of high probability; it is evidence so clear as to leave no substantial doubt, or sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Applicable Statutes

2. The primary purpose of disciplinary action is to protect the public. (Bus. & Prof. Code, § 2229, subd. (a).) The Medical Practice Act emphasizes that the board should "seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove

those deficiencies." (Bus. & Prof. Code, § 2229, subd. (c).) However, "[w]here rehabilitation and protection are inconsistent, protection shall be paramount." (Bus. & Prof. Code, § 2229, subd. (c).)

3. Business and Professions Code section 2227 provides that a licensee who is found to have violated the Medical Practices Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay costs of probation monitoring, be publicly reprimanded, or such other action taken in relation to the discipline as the board deems proper.

4. Under Business and Professions Code section 2234, the board shall take action against a licensee charged with unprofessional conduct. Grounds for unprofessional conduct include, but are not limited to, gross negligence (subdivision (b)), repeated negligent acts (subdivision (c), incompetence (subdivision (d), and failure of a certificate holder who is the subject of an investigation by the board to participate in an interview by the board (subdivision (g).)

5. It is also unprofessional conduct for a physician and surgeon to fail to maintain adequate and accurate records relating to the provision of services to his or her patients. (Bus. & Prof. Code, § 2266.)

The Standard of Care, Gross Negligence, and Simple Negligence

6. Medical providers must exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances. (*Powell v. Kleinman* (2007) 151 Cal.App.4th 112, 122.) Because the standard of care is a matter peculiarly within the knowledge of experts, expert testimony is required to prove or disprove that a medical practitioner acted within the

standard of care unless negligence is obvious to a layperson. (*Johnson v. Superior Court* (2006) 143 Cal.App.4th 297, 305.)

7. "Gross negligence" long has been defined in California as either a "want of even scant care" or "an extreme departure from the ordinary standard of conduct." (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 195-198; *City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 753-754.)

8. Ordinary or simple negligence has been defined as a departure from the standard of care. It is a "remissness in discharging known duties." (*Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279; *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1055-1056.)

9. Repeated negligent acts mean one or more negligent acts; it does not require a "pattern" of negligent acts or similar negligent acts to be considered repeated. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

10. A physician's failure to complete or maintain patient records can constitute gross or simple negligence, depending on the circumstances. (*Kearl v. Board of Medical Quality Assurance, supra, at pp.* 1054.)

Disciplinary Guidelines

11. California Code of Regulations, title 16, section 1361, provides that when reaching a decision on a disciplinary action, the board must consider and apply the "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (12th Edition/2016). Under the Guidelines the board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake board-ordered rehabilitation, the age of the case, and evidentiary problems,

Administrative Law Judges hearing cases on behalf of the board and proposed settlements submitted to the board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

12. Under the Disciplinary Guidelines, the minimum discipline for gross negligence, repeated negligence, incompetence, and failure to maintain adequate medical records is a stayed revocation for five years. The Disciplinary Guidelines provide that in cases charging repeated negligent acts with one patient, a public reprimand may, in appropriate circumstances, be ordered. The maximum discipline is revocation. Among the conditions of probation, the guidelines recommend an education course, medical record keeping course, professionalism program (ethics course), clinical competence assessment program, a practice monitor, and solo practice prohibition.

Evaluation

13. Respondent provided follow-up care to Patient A after the December 2014 surgery from January 2015 to May 27, 2015, a period of five months. Respondent, as well as both experts in this matter, all agreed that if the surgical wound had continuous discharge of fluid after surgery for a period of five months, then this is indicative of possible infection, and respondent would be required to take steps to rule out an infection. However, respondent and his expert dispute Patient A and Dr. Miller's contention that the wound had continuous discharge during that time period. Specifically, Dr. Sanzone opined that during the five-month period of care from respondent, Patient A's wound appeared to be healing well and had stopped draining in February 2015, but later developed two stitch abscesses in May 2015, which

respondent treated appropriately. However, Dr. Miller opined that the medical records, as well as Patient A's deposition testimony, established that Patient A had continuous drainage from the surgical wound during the five-month period, and respondent's failure to assess that wound to rule out infection during that time period constituted gross negligence, incompetence, and repeated negligent acts. A fundamental issue in this matter is whether the wound was draining during the entire five-month period.

Respondent admitted that his medical records for Patient A during that time period were less than desirable. Both experts agreed that the medical records were insufficient, and Dr. Sanzone testified that there were multiple entries in those medical records that were ambiguous such that he did not understand them. Dr. Sanzone also stated multiple times during his testimony that he did not see Patient A's wound, and as a result could not make a specific determination regarding the state of Patient A. Instead, he relied solely on respondent's insufficient medical records, as well as what respondent told him during a meeting about what those medical records meant and what respondent observed and recalled. 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.) Given that respondent has an obvious bias to protect his license, and Dr. Sanzone's opinions were based on respondent's version of events based on his recollections, most of which were not recorded in the medical records, Dr. Sanzone's opinions are found less reliable than those of Dr. Miller.

14. There were multiple indications that Patient A continued to have drainage from his ankle in May 2015, in addition to Patient A's deposition testimony to that effect. Specifically, the medical records from May 13, 2015, show that Patient A's chief complaint during that visit was "drainage on leg." However, respondent testified

that he only saw two tiny stitch abscesses on the lateral and medial aspects on that date, and they had "very little drainage." The medical records for that date record nothing regarding the amount of drainage and only state "stitch abscesses – lateral and medial." The medical records from May 27, 2015, show that respondent recorded that Patient A was having "minimal drainage," which Dr. Sanzone testified was ambiguous. Notably, respondent did not qualify the "minimal drainage" comment by saying that it was from a stitch abscess on this date, which would lead a reader to understand that the minimal drainage was from the wound itself. All of these records demonstrate that in May 2015 Patient A was having some drainage from his ankle, which, as Dr. Miller testified, is an indication of infection because this was five months after surgery.

Both Dr. Miller and Dr. Sanzone agree that smoking can hinder wound healing because of decreased circulation and, as a result, can increase the risk of infection. Dr. Sanzone admitted that if the patient continued to have drainage five months after surgery that it would be a concern for infection, particularly for a smoker. Dr. Miller's opinion that respondent's failure to rule out an infection in Patient A in May 2015 was an extreme departure from the standard of care and constitutes gross negligence is found more persuasive than the opinion of Dr. Sanzone that respondent's treatment of Patient A in May 2015 was appropriate. Additionally, respondent's failure to rule out infection on the next visit of May 27, 2015, when Patient A continued to have drainage, constitutes repeated negligent acts for the same reasons as stated above. Furthermore, Dr. Miller's opinion that respondent departed from the standard of care because he failed to recognize the signs of an infection in Patient A, and minimized the infection as a stitch abscess, despite the fact it was seen on both wounds (medial and lateral), is found more persuasive that Dr. Sanzone's contrary opinion given the other indications in the record that Patient A continued to have drainage from the

wound. Respondent's failure to recognize the signs of infection constitutes incompetence.

Moreover, Dr. Miller opined that respondent's failure to follow-up with Patient A for four months after his last visit when Patient A was still experiencing wound drainage effectively guaranteed that Patient A's infection would progress to the bone because it was untreated. Dr. Miller characterized respondent's failure to follow-up for four months as an extreme departure from the standard of care, constituting gross negligence. Dr. Sanzone's opinion that respondent's actions in waiting four months for follow-up on the patient because of insurance issues was appropriate in those circumstances was less persuasive. Given the risk of infection in this smoking patient, the presence of drainage at all would dictate that a reasonable physician would follow the patient more closely to make sure no infection was present. Complainant established by clear and convincing evidence that respondent's failure to follow-up with the patient for four months after the May 27, 2015, visit was an extreme departure from the standard of care constituting gross negligence.

15. Dr. Miller also opined that respondent's failure to "work up" the insensate foot issue on Patient A to determine its cause was a simple departure from the standard of care. However, Dr. Miller acknowledged that he had insufficient information in the medical records to even opine as to whether this was a serious issue. Dr. Miller also provided no information regarding what, if anything, respondent should have done to "work-up" the insensate foot. In comparison, Dr. Sanzone and respondent both credibly testified that the insensate foot issue was caused by the original trauma and there was no treatment or useful diagnostic tools to "work up" the insensate foot. Accordingly, complainant did not establish by clear and convincing

evidence that respondent deviated from the standard of care for his treatment of the insensate foot issue on Patient A.

16. Complainant established by clear and convincing evidence that respondent's medical recordkeeping for Patient A fell below the standard of care of a reasonable physician. Respondent admitted that his recordkeeping in this matter was less than desirable. Dr. Sanzone admitted that the records for Patient A were at times ambiguous and incomplete. Dr. Miller opined that respondent's failure to properly document Patient A's condition and care constituted a simple departure from the standard of care and is found persuasive.

17. Finally, the accusation alleges that respondent failed to participate in an interview with the board regarding this matter. While the evidence shows that respondent's office manager was not punctual in his response to the board's requests for an interview of respondent, he did provide possible interview dates. Additionally, issues such as Ms. Peterson's maternity leave and failure to issue a subpoena to respondent because of her concern regarding a telephonic/video interview in light of the COVID-19 pandemic contributed to the delay in interview scheduling. Also, the July 31, 2020, telephone conversation where the possibility of using a letter of explanation rather than an interview possibly contributed to a delay in obtaining an interview in this matter. After a consideration of all the evidence, complainant did not establish by clear and convincing evidence that respondent failed to participate in an interview with the board without good cause.

Cause Exists to Discipline Respondent's License

18. Cause exists under Business and Professions Code section 2234, subdivision (b), to impose discipline. Complainant established by clear and convincing

evidence that respondent engaged in gross negligence with respect to his care and treatment of Patient A for failing to rule out an infection in May 2015 when Patient A continued to have drainage, and for failing to follow-up with Patient A for four months after the May 27, 2015, visit despite the presence of continued drainage in Patient A's foot.

19. Cause exists under Business and Professions Code section 2234, subdivision (c), to impose discipline. Complainant established by clear and convincing evidence that respondent engaged in repeated acts of negligence with respect to Patient A for failing to rule out an infection on at least two occasions in May 2015, and failing to maintain proper and adequate medical records for Patient A.

20. Cause exists under Business and Professions Code section 2234, subdivision (d), to impose discipline. Complainant established by clear and convincing evidence that respondent lacked necessary knowledge and was incompetent in his treatment of Patient A due to his failure to recognize the signs of an infection in Patient A in May 2015.

21. Cause exists under Business and Professions Code section 2266 to impose discipline. Complainant established by clear and convincing evidence that respondent maintained inadequate or inaccurate medical records with respect to Patient A by failing to properly document the presentation of Patient A's ankle, as well as the status of Patient A's condition.

22. Cause does not exist under Business and Professions Code section 2234, subdivision (g), to impose discipline. Complainant did not establish by clear and convincing evidence that respondent failed to participate in an interview with the board without good cause.

Application of Disciplinary Guidelines

23. Because cause for discipline exists, a determination of the degree of discipline necessary must be made with application of the Disciplinary Guidelines. Respondent has had no history of prior discipline and has a long history of providing competent medical care in a very busy practice for over 22 years. He has had a good reputation in the community and as a physician. Dr. Lenihan practices in his community and praised respondent's professionalism, work ethic, and quality of patient care. Mr. Velez praised respondent's outstanding leadership, professionalism, and patient care, and noted how respondent has one of the lowest rates of infection in the community when compared to the national standard. Substantial evidence established that respondent has a long history of providing excellent care to patients. Also, respondent has taken steps to address his issues with medical record documentation by completing a medical recordkeeping course and implementing EMR in his office.

24. The allegations in this accusation involve only one patient, who had a complicated injury and surgery and was at high risk of complications because he was a smoker. The issues regarding this one patient occurred about six years ago and there have been no further incidents regarding patient care since that time. The Disciplinary Guidelines provide that in a situation where there are repeated negligent acts involving only one patient, a public reprimand may be appropriate. However, respondent's lack of knowledge regarding recognition of infection in Patient A and his sparse and insufficient medical record keeping raises concerns for public safety. Upon consideration of all the evidence in this matter, public protection dictates that a probationary period with appropriate terms and conditions is the appropriate discipline under these circumstances. However, given the mitigating factors in this case

as discussed above, a reduction in the recommended probationary period of five years to a period of two years is appropriate, particularly given the steps respondent has already taken to address his medical recordkeeping issues and the time that has elapsed since his treatment of Patient A without further incidents.

25. The public will be protected by placing respondent's certificate on probation for two years, with requirements that he complete certain educational and medical record keeping courses, and ethics courses; he complete a clinical competence assessment program; be subject to a practice monitoring requirement; and be prohibited from having a solo practice. The additional optional conditions recommended in the guidelines including a prescribing practices course and prohibited practice are not appropriate for the circumstances of this case and are therefore not required for public protection. The probation requirements imposed are designed to remediate respondent's deficiencies and ensure that he practices in a safe and professional manner.

ORDER

IT IS HEREBY ORDERED that respondent's Physician's and Surgeon's Certificate, No. G 84284 is revoked. However, the revocation is stayed, and respondent is placed on probation for two years from the effective date of this Decision on the following terms and conditions:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational

program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course no 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. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

At the end of the evaluation, the program will submit a report to the board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

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

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

5. 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 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.

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

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

If, during the course of the probation, respondent's practice setting changes and respondent is no longer practicing in a setting in compliance with this Decision,

respondent shall notify the board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

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

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

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

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

10. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit. Respondent shall comply with the board's probation unit and all terms and conditions of this decision.

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

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

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

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

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

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

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

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current

version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

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

14. 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, 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.

15. LICENSE SURRENDER. Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of her license. The board reserves the right to evaluate respondent's request and to exercise its discretion 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.

16. 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.

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

DATE: January 21, 2022

Debra D. Nye-Perkins

DEBRA D. NYE-PERKINS
Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the Accusation Against:	Case No. 800-2017-039857
Harbinder Singh Chadha, M.D. **955 Lane Avenue, #200** **Chula Vista, CA 91914** **Physician's and Surgeon's Certificate No. G 84284,** Respondent.	**A C C U S A T I O N**

PARTIES

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

2. On or about December 12, 1997, the Medical Board issued Physician's and Surgeon's Certificate No. G 84284 to Harbinder Singh Chadha, 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 June 30, 2021, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code provides 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 costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

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

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

FIRST CAUSE OF DISCIPLINE

(Gross Negligence)

7. Respondent has subjected his Physician's and Surgeon's Certificate No. G 84284 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of

the Code, in that he was grossly negligent in his care and treatment of Patient A, as more particularly alleged hereafter:

8. On or about December 27, 2014, Patient A[1] fell from a ladder and sustained serious injuries. As a result, Patient A was admitted to S. G. Hospital. Patient A was a 62-year-old male at the time of the incident.

9. From December 27, 2014, through December 30, 2014, Respondent treated Patient A for a bimalleolar ankle fracture.

10. On or about December 28, 2014, Respondent performed surgery on Patient A. Patient A was given prophylactic antibiotics at the beginning of the procedure. Respondent proceeded with irrigation and debridement, repair of skin laceration, and internal fixation of the ankle fracture with sydesmosis. On or about December 30, 2014, Respondent was discharged from S.G. Hospital.

11. On or about January 12, 2015, Respondent saw Patient A for his first follow-up appointment, following surgery. Patient A presented with a chief complaint of "check surgery drainage." Respondent's notes are limited to "medical wound," "no erythema," and "1cm x 1cm." Respondent's recorded treatment plan for Patient A was "dressings change BID change x 6 wks." Respondent obtained no cultures and ordered no lab work for Patient A to determine if an infection was present.

12. On or about February 9, 2015, Patient A had another follow-up appointment with Respondent. Respondent in his medical record noted that Patient A had a "2mm left in medial wound." Respondent also wrote a prescription for Norco for patient A.

13. On or about February 23, 2015, Patient A's x-ray report indicated "+ fracture angulation/displacement."

14. On or about May 13, 2015, Patient A was treated by Respondent. Patient A's chief complaint was "drainage on the left." Respondent's only written observations were "stitch

[1] To protect the privacy of the patient involved, the patient's name has not been included in this pleading. Respondent is aware of the identity of the patient referred to herein.

abscesses-lateral and medial." No wound cultures or lab work was ordered by Respondent for Patient A.

15. Patient A's primary care physician Dr. B. L. referred Patient A to Dr. F.K after Patient A continued to have drainage issues and pain following surgery performed by Respondent.

16. On or about August 22, 2015, after Patient A continued to experience drainage issues for the preceding few months, Patient A saw Dr. F. K. Dr. F.K. noted that following surgery, Patient A had persistent drainage from his wounds. Patient A attended physical therapy and continued to have increased ankle pain. Patient A's pain was exacerbated by weight bearing activity and exercise.

17. Dr. F.K. noted that Patient A had been evaluated by Dr. D. F. who performed wound cultures. Patient A's outpatient wound cultures revealed evidence of growth for staphylococcus aureus, as well as, Enterobacter species. Patient A also underwent x-rays and a CT scan, and a MRI scan, which revealed a serious left ankle infection. To correct Patient A's surgery by Respondent, Patient A subsequently underwent a tibial-talar-calcaneal ("TTC") fusion.

18. Respondent committed gross negligence in his care and treatment of Patient A by failing to diagnose Patient A's post-operative infection resulting in Patient A needing additional surgery.

SECOND CAUSE OF DISCIPLINE

(Repeated Negligent Acts)

19. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 84284 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, as more particularly alleged in paragraphs 8 through 18, above, which are hereby incorporated by reference and reallaeged as if fully set forth herein.

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THIRD CAUSE OF DISCIPLINE

(Incompetence)

20. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 84284 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he has demonstrated incompetence in his care and treatment of Patient A, as more particularly alleged in paragraphs 9 through 18, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE OF DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

21. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 84284 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient A, as more particularly alleged in paragraphs 9 through 18, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE OF DISCIPLINE

(Failure to Participate in Interview)

22. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 84284 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (g), of the Code, in that Respondent without good cause failed to attend and participate in an interview by the board, as a subject of a board investigation, as more particularly alleged hereinafter:

A. On or about February 13, 2020, an Investigator for the Board (Board Investigator) called Respondent's office and spoke with T.R., his office manager. T. R. indicated he would assist in scheduling a subject interview of Respondent for the Board Investigator. The Board Investigator received a follow-up email from T.R. stating he would check with Respondent about his availability for an interview.

B. On or about February 23, 2020, the Board Investigator emailed T. R. to follow up on Respondent's availability for an interview.

C. On or about February 27, 2020, the Board Investigator called T.R. and received dates Respondent would be available for a subject interview. The Board Investigator informed T.R. that her supervisor would conduct the interview because she would be on maternity leave.

D. On or about March 11, 2020, the Supervising Special Investigator for the Board called T.R. to request Respondent's interview take place on April 7, 2020. A response was never received.

E. On or about June 12, 2020; June 26, 2020; June 30, 2020, the Board Investigator contacted T.R., Respondent and Respondent's office via email and telephone to obtain a time and date to schedule Respondent's subject interview. The Board investigator received no response.

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 No. G 84284, issued to Harbinder Singh Chadha, M.D.;

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

3. Ordering Harbinder Singh Chadha, 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: 12-15-2020

FOR: WILLIAM PRASIFKA REJI VARGHESE DEPUTY DIRECTOR
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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