800BEFORE THE
MEDICAL BOARD OF CALIFORNIA
STATE OF CALIFORNIA

In the Matter of the Accusation against:

Quinn Li, M.D., Respondent

OAH No. 2018080648

Case No. 800-2016-028347

DECISION AFTER SUPERIOR COURT REMAND

This matter was originally heard by Erin R. Koch-Goodman, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, on July 15, 16, 17, 18, and 19, 2019, in Sacramento, CA.

Rebecca D. Wagner, Deputy Attorney General (DAG), appeared on behalf of the executive director of the Medical Board of California (Board), Department of Consumer Affairs (Complainant).

Nicole Hendrickson, Attorney at Law, LaFollette, Johnson, DeHass, Fesler & Ames, appeared on behalf of Quinn Li, M.D. (Respondent), who was present at hearing.

The record was closed and the matter was submitted for decision on October 7, 2019. The ALJ issued a proposed decision dismissing the accusation on November 18, 2019.

On February 5, 2020, Panel A of the Board issued an Order of Non-Adoption of Proposed Decision. Oral argument on the matter was heard by Panel A on May 7, 2020, with ALJ Coren Wong presiding. DAG Rebecca Wagner represented

Complainant. Respondent was present and was represented by Attorney Nicole D. Hendrickson. Panel A read and considered the entire record, including the transcript and the exhibits and the written and oral arguments, and entered a Decision After Non-Adoption revoking Respondent's license, staying the revocation, and placing him on three years' probation with terms and conditions. The Decision from the Board was effective on June 26, 2020.

On June 3, 2020, Respondent filed a Verified Petition for Administrative Writ of Mandate. Ultimately, on March 10, 2022, the Superior Court of California in Sacramento County issued a Peremptory Writ of Mandamus that commanded the Board to set aside its 2020 Decision After Non-Adoption, and to fully restore Respondent's license subject to the disposition as stated in the Court's Judgment and Final Ruling issued on February 22, 2022 (attached). The Superior Court's Judgment and Final Ruling granted in part and denied in part Respondent's Petition for Writ of Mandamus. The Superior Court partially granted the writ petition by finding that the Board's Decision finding Respondent guilty of gross negligence and repeated negligent acts must be set aside, because the weight of the evidence did not support those causes for discipline. The Superior Court, however, partially denied the writ petition and upheld the Board's finding of cause for discipline for unprofessional conduct for failure to maintain adequate and accurate medical records under Business and Professions Code section 2266.

Following the Superior Court remand, oral argument on the matter was heard by Panel A on May 19, 2022, with ALJ Marcie Larson presiding. DAG Lynne Dombrowski represented Complainant. Respondent was present and was represented by Attorney Nicole D. Hendrickson. Panel A, having read and considered the entire record, including the transcript and the exhibits, the Superior Court's Order, and the written and oral arguments, hereby enters this Decision After Superior Court Remand.

FACTUAL FINDINGS

1. On July 1, 2004, the Board issued Respondent Physician's and Surgeon's Certificate (license) No. A 87986. Respondent's license is in full force and effect until July 31, 2022, unless renewed or revoked.

Accusation

2. On April 10, 2018, Complainant, in their official capacity, made and served an Accusation against Respondent, seeking to discipline his license for acts of gross negligence, repeated acts of negligence, and failure to maintain adequate and accurate medical records during his treatment of A.P. on August 10, 2016. More specifically, Complainant alleges Respondent failed to: document an adequate medical history, abnormal vital signs and an accurate heart examination; diagnosis A.P. with dehydration and incorrectly diagnosed A.P. with non-infectious gastroenteritis; test A.P.'s orthostatic vital signs (OVS), test for a urinary tract infection (UTI), and conduct blood tests; treat A.J. with the proper medication; and document patient status and vital signs prior to discharge, spend sufficient time with A.P. to assess and reassess before discharge, or provide sufficient discharge instructions.

3. On April 13, 2019, Respondent timely filed a Notice of Defense, requesting an administrative hearing before OAH, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500, et seq. This hearing followed.

Background

4. Respondent was born and raised in China. He completed a Medical Degree in 1986 and a Master of Science in 1989 from Sun Yet-sen University of Medical Sciences. In 1990, Respondent moved to the United States, and began a Doctorate of Philosophy in pathology at the University of Medicine and Dentistry of New Jersey. He completed his Doctorate in 1995. From 1996 to 2000, he was a resident in internal medicine and pediatrics at Overlook Hospital at Columbia

University, New Jersey. In 2000, Respondent was licensed to practice medicine in New Jersey. From 2000 to 2005, Respondent worked as an emergency department (ED) physician in Trenton, New Jersey. In 2004, he became licensed to practice medicine in California, and in 2005, Respondent began practicing in California as an ED physician in Sacramento at Sutter Medical Center. He is Board Certified in internal medicine (2000, recertified in 2012), and was Board Certified in Pediatrics from 2000 to 2014. Respondent has treated ED patients for 11 years, and has treated urgent care patients for an additional 11 years. Respondent has no prior discipline history.

5. Currently, Respondent is a primary care physician (PCP) at Lincoln Associates Inc., serving a population of 3,000 seniors. He is also the owner/operator of several urgent care facilities in the greater Sacramento area, including the Elk Grove and Sacramento Urgent Care Clinics. The conduct at issue occurred at the Sacramento Urgent Care Clinic on August 10, 2016, when Respondent provided care and treatment to a 16-year-old adolescent complaining of low back pain, nausea, vomiting, and diarrhea.

Conduct at Issue

6. On August 10, 2016, A.R. drove her son, A.P., to the Sacramento Urgent Care Clinic. A.R. checked-in with the receptionist and was asked to complete a two-page information sheet, seeking, among other things: reason for the visit - "back hurt, throw up, weak, headach[e]" and PCP - Ravinder Khaira, M.D. A.R. then submitted the completed information sheet, her insurance card and driver's license to the receptionist. At 1:59 p.m., the receptionist printed patient stickers for A.P. (name, social security number, birthdate, age, visit date and time) and placed a sticker at the top of each page of a three-page pro-forma Evaluation/Management (E/M) form (medical record). A.P. was nauseous and asked to use the bathroom. A.P. and A.R. were directed to the bathroom located inside the treatment area; they walked passed Respondent, who was sitting at the Nurses Station. From outside the bathroom, Respondent could hear A.P. heaving and vomiting. A.P. and A.R. exited the bathroom and Medical Assistant (MA) Jordan Gill led them through the treatment area to

Examination Area 2 (Exam 2). MA Gill confirmed A.P.'s date of birth (16 years and three months old), took A.P.'s vital signs, and questioned A.P. about his main problem and symptomology.

MA Gill recorded his findings in the medical record, as follows: blood pressure (BP) - 164/94, pulse (P) - 142, temperature (T) - 99.9 degrees Fahrenheit, oxygen saturation - 96 percent, weight and height were left blank[1]; Main Problem - Pain; Date of onset - August 7, 2016; Where is it - Back; Makes worse/better - Not Applicable; Timing of Pain is - Constant; Related Symptoms - Nausea, vomiting, diarrhea; Severity of Pain - Pain/Discomfort 10 of 10; Quality of Pain - Sharp; What caused Pain - Not injury, Not motor vehicle accident, Not work-related; Chronic/Inactive Conditions - None; Current Medications - None; Family History - None; Tobacco and Alcohol - Never; Street Drugs - No; Allergies - Negative Acknowledgement. MA Gill left A.P. and A.R. and provided A.P.'s medical record to Respondent at the Nurses Station.

7. Respondent reviewed A.P.'s medical record, entered Exam 2, and met A.P. and A.R. Respondent questioned A.P. and A.R. about the main reason for the visit. Respondent did not repeat medical history questions; instead, relying on the MA and his documentation in the medical chart. Following the physical examination, Respondent documented "normal/negative" in the medical chart for all of the following categories:

> well-developed, well-nourished (WDWN); Eyes (icteric or injected conjunctivae); Musculoskeletal (gait and station); Ear, Nose, and Throat (mouth pallor of oral mucosa, ear pinnae and external nose, tympanic membrane and ear canal red and/or bulging, tenderness of sinuses on percussion); Lymph nodes (cervical or inguinal lymphadenopathy); skin (rashes, cyanosis, ecchymosis, or laceration, warm, cool or tender on palpation); Respiratory

[1] The same day at the Sutter ED, A.P. weighed 379 pounds.

(respiratory distress - retraction, access, muscles, diaphragm movement), Auscultation (breath sounds, crackles, rubs, wheezing); Cardiac (heart auscultation - murmurs, rubs, gallops, clicks, pretibial or pedal edema); Gastrointestinal/abdomen (tenderness or mass to palpation, liver and spleen enlarged or tender, punch tenderness for involvement of diaphragm, liver, spleen); and Neurological (cranial nerves II-XII ([i.e., oculomotor nerve (III), trochlear nerve (IV), abducens nerve (VI), vestibulocochlear nerve (VIII), glossopharyngeal nerve (IX), vagus nerve (X), and hypoglossal nerve (XII)]).

Respondent drew an arrow from GI/abdominal and handwrote: "tender to lower back." Respondent documented a diagnosis in the medical record by marking the following boxes: Nausea with emesis; Gastroenteritis/enteritis/colitis, not infectious; and back pain. Respondent ordered Toradol, 60 milligrams (mg.) injection, for the back pain, and prescribed Zofran 8mg. ODT (orally disintegrating tablets) for the nausea.

8. Respondent left A.P. and A.R. and directed MA Gill to administer the Toradol injection. Respondent went to the nurses' station and began A.P.'s discharge paperwork. At approximately 2:13 p.m., Respondent printed discharge instructions for A.P. for the topics of Gastroenteritis (two pages) and Food Poisoning (two pages). The discharge instructions included directions to "Get Prompt Medical Attention if any of the following symptoms occur," including "increasing abdominal pain or constant lower right abdominal pain, continued vomiting (unable to keep liquids down), frequent diarrhea (more than 5 times a day) . . . ." In addition, Respondent added, after "Special Advice: [go] back or go to the ER for worsening pain or fever."

9. At approximately 2:13 p.m., MA Gill reentered Exam 2 and administered A.P. a Toradol injection. MA Gill told A.P. to wait in Exam 2 and he would return in 10 minutes to check on him. MA Gill returned 10 minutes later, finding A.P. to be "good,"

noting the same in the medical chart. At approximately 2:23 p.m., A.P. was released and walked out of the Sacramento Urgent Care Clinic on his own accord.

Consumer Complaint

10. On December 2, 2016, A.R. filed a Consumer Complaint with the Board, alleging Respondent provided substandard care to her son, A.P., on August 10, 2016, at Sacramento Urgent Care, 7200 South Land Park Drive. She wrote:

> Took my son to urgent care. Doctor Li said he had food poisoning. He never asked his history or did any tests. My son drank a gallon of water. Dr. Li never asked if he was diabetic [illegible]. We were there only 20-25 minutes. Dr. Li gave him medicine for vomiting and a shot for pain. Got there at 1:59 p.m. Later that night, my son was worse so I took him to Sutter Medical Center. He was there for 2 days and died of cardiac arrest, respiratory arrest, diabetic ketoacidosis and acute pancreatitis, [and] diabetes. I feel Dr. Li misdiagnosed my son and didn't recognize how sick he was. He did <u>not</u> have food poisoning.

Board Investigation

11. The Board, in turn, provided the Complaint to Respondent and asked for a written response. On December 30, 2016, Respondent submitted a Statement of Care (Statement) to the Board, writing, in part:

> I have reviewed the record of the visit. [A.P.] came to Sacramento Urgent Care on 8/10/16 with his mother. He complained of back pain, vomiting and diarrhea for 3 days. We . . . asked if he had any chronic/inactive medical conditions and was taking medications. Based on the record, it was denied for any chronic medical conditions or

medications suggesting he was diabetic. On my physical exam, he was alert and walked with a normal gait. His skin was warm with normal color. He had no acute distress with normal breathing and oxygenation. He was not hypotensive. He was in pain/nausea and had a low grade Temp of 99.9F, which made it hard to assess his pulse rate. He had no tenderness in the abdomen. He had a muscular tenderness in the lower back, which could be caused by straining during vomiting. At that point, he had no clinical signs of severe dehydration or ketoacidosis. In an outpatient setting, the standard of care is symptomatic relief and oral rehydration. For an otherwise healthy 16 yr old patient, it was not warranted to do laboratory tests at that early stage of the disease, but to observe the progression. We gave him intramuscular injection of Toradol 60 mg to relieve his pain. After the injection, he was rechecked and his status was good. He was discharged with a prescription of Zofran 8 mg for nausea and continued oral hydration at home. He was given a detailed discharge instruction material for gastroenteritis and oral rehydration. I specifically advised him to come back or go to ER for worsening pain and fever.

12. On April 30, 2017, the Board opened an investigation, and assigned the case to Special Investigator Belen Buntin. Ms. Buntin obtained A.P.'s medical records from Sutter Medical Center and Sacramento Urgent Care for August 10, through 12, 2016; interviewed A.R. on May 31, 2017, and Respondent on September 14, 2017; and obtained the expert medical opinion of Soni Nageswaran, M.D., on whether Respondent practiced within the standard of care for an urgent care doctor when he treated A.P. on August 10, 2016.

13. On January 3, 2018, Ms. Buntin issued an Investigative Report, summarizing her findings regarding the care and treatment of A.P. On September 9, 2018, after acquiring additional information, including the civil deposition transcripts of A.R. and Respondent, Respondent's curriculum vitae (CV), and all medical records for A.P. from Sacramento Urgent Care (August 10, 2016, and June 23, 2015 – ear infection), Ms. Buntin issued a Supplemental Investigation Report. Ms. Buntin testified at hearing consistent with her reports.

Medical Opinions

BOARD EXPERT – DR. SONI NAGESWARAN

14. Dr. Nageswaran completed a Bachelor of Art in biology in 1996, at Johns Hopkins University in Baltimore, Maryland. She earned a Medical Degree in 2001, from the University of Michigan Medical School, in Ann Arbor. Dr. Nageswaran then completed a three-year residency in family medicine at the University of California (UC), Davis Medical Center. In 2003, she became licensed to practice medicine in California, and she has been Board Certified by the American Board of Family Medicine, since 2004.

15. Dr. Nageswaran has practiced medicine for 16 years, treating patients in outpatient clinics, a managed primary care office, an urgent care center, and a Veteran's Affairs emergency department. Currently, Dr. Nageswaran works for Sacramento County Correctional Health treating jailed men and women. She was a Board Medical Consultant from 2007 to 2008, and a Board Expert Reviewer from 2007 to 2009, and again from 2015 to the present. She has reviewed approximately nine cases for the Board, including this case, with all cases related to the standard of care. She has never testified before this hearing.

16. The Board retained Dr. Nageswaran to conduct a review of documents and provide an opinion as to whether Respondent acted within the medical standard of care when he treated A.P. On October 24, 2017, the Board provided Dr. Nageswaran with the following documents for her review: Consumer Complaint,

Respondent's Statement of Care, medical records for A.P. from Sutter Medical Center and Sacramento Urgent Care from August 10, through 12, 2016; Respondent's Board interview transcript; and the Board Investigative Report.

17. On November 29, 2017, Dr. Nageswaran drafted an Expert Report, finding Respondent departed from the standard of care on 13 occasions when treating A.P.: five extreme departures and eight simple departures. On September 22, 2018, Dr. Nageswaran issued an addendum (Addendum 1), after reviewing new information, including the Board Supplemental Investigative Report, A.R.'s and Respondent's civil deposition transcripts, and all medical records for A.P. from Sacramento Urgent Care, adding an additional simple departure. On March 16, 2019, Dr. Nageswaran issued another addendum (Addendum 2), correcting the dates A.P. entered Sutter Medical Center and died: the dates "are listed as 12/11/16 and 12/12/16, instead of 8/11/16 and 8/12/16, respectively." Dr. Nageswaran testified at hearing consistent with her Report and addendums.

18. To evaluate Respondent's care and treatment of A.P., Dr. Nageswaran compared it to the "community or professional expectation of practice in a particular clinical setting, based on medical training, textbooks, and hands-on training [or] how would [she] respond or act" if treating the same patient in the same environment. For Dr. Nageswaran, a simple departure "is not a huge error in judgement; not a completely uncommon practice; something seen before; not egregious." An extreme departure from the standard of care "may be more egregious; a commission or omission that may have consequences to the patient; something strange or surprising to see." Dr. Nageswaran opined in this case, an urgent care setting, a physician must identify the patient's chief complaint and symptoms; ask questions and conduct a relevant physical examination; and develop a diagnosis, treatment and follow-up plan. In addition, the physician must "document all pertinent positives and negatives, as well as the thought-process/decision-making for diagnosis."

19. Overall, Dr. Nageswaran was critical of Respondent's medical recordkeeping, noting repeated failures to: document pertinent positives and

negatives; provide rationale for selecting diagnoses (e.g., non-infectious gastroenteritis), rejecting diagnoses (e.g., dehydration and urinary tract infection), not ordering tests (e.g., blood tests), and medication choices (e.g., Toradol and Zofran); and specify the nature and quality of each system examined (e.g., cardiovascular – tachycardic). More specifically, Dr. Nagaswaran found Respondent made 10 simple departures and five extreme departures. The simple departures include failing to: document sinus rhythm following a heart rate in the 140s; take OVS to access dehydration; order blood tests; conduct an oral fluid tolerance test in a patient with gastrointestinal symptoms and an elevated heart rate; document patient's initial clinical status as "uncomfortable"; diagnose dehydration; spend an adequate amount of time assessing and reassessing A.P.; and provided incomplete discharge instructions to A.P. In addition, Respondent: used Toradol, 60 mg., a high dose NSAID, with side effects including gastric upset, in a patient with acute vomiting; and incorrectly documented non-infectious cause for acute gastroenteritis.

The extreme departures include failing to: document pertinent positives and negatives in the medical chart regarding the physical examination of A.P.; order a urinalysis in a patient presenting with an elevated temperature, low back pain, nausea, and vomiting; and document patient's improvement in clinical status before discharging patient. In addition, Respondent incorrectly noted a normal heart examination immediately following the taking of an elevated heart rate, and failed to repeat vitals prior to discharge; and a normal heart examination, without specifying heart rate or type of improvement in a patient who presented with significant tachycardia.

Examination

20. **Medical History**. In the urgent care setting, a "focused history" should be taken, tailored to the patient's presenting complaint. For a physical, it is important to note aspects of the exam that are noted to be present or absent which might directly relate to a possible diagnosis being ruled in or out. In this case, the medical record shows no past medical conditions, family history, past surgical history, social

history, and medications. The entire Review of Systems was left blank, with no positives and negatives listed, suggesting that these items were not reviewed.

The physical examination section shows several systems evaluated, but all are checked off as normal with no qualifiers. The only pertinent finding written was "tender to low back," though this does not clarify which side, if it was palpation versus percussion, if there was spasm or mobility impairment, or other findings to suggest pure musculoskeletal cause to explain A.P.'s back pain of 10/10. In addition, more specific gastrointestinal and urological history or physical questions/examinations were not specifically noted, though these would be pertinent in helping characterize the nature of the patient's symptoms, narrow down possible etiologies, and support Respondent's medical decision-making. With the exception of one note "tender to lower back," Respondent simply checked boxes on the E/M form. Dr. Nageswaran testified that the standard of care also requires a more detailed description of A.P. and his pain (e.g., radiating/tingling; back only – middle or sides; leg pain too).

21. **Abnormal Vital Signs & Heart Examination**. A.P. had a high pulse rate - 142 (normal 60-100); high blood pressure - 164/94 (normal 100-120/60-70); a slightly elevated temperature - 99.9 degrees Fahrenheit (normal 98.6 degrees); and a slightly elevated respiratory rate - 22 (normal 20). Together, Dr. Nageswaran found A.P.'s vital signs to be "abnormal" and "very concerning" and without additional testing and/or improvement in vital signs, Dr. Nageswaran would not have sent A.P. home.

In addition, Dr. Nageswaran questions the accuracy and reliability of Respondent's physical examination of A.P. Respondent checked the box marking A.P.'s heart exam as normal, less than 10 minutes after his pulse rate was 142 or tachycardic. In his Board interview, Respondent said he marked normal because A.P.'s heart rate was between 110-120 during the physical examination. However, there is no heart rate or sinus rhythm listed in A.P.'s medical chart for Respondent's examination, no EKG was performed, and no follow-up vitals were taken to confirm. Failure to document a sinus rhythm is a simple departure, and if Respondent had documented a heart rate of below 120, then there was no departure from the standard of care.

Diagnosis

22. **Dehydration.** A.P. presented with symptoms concerning for dehydration, and Respondent should have documented specifics associated with dehydration in the history and physical (e.g., skin turgor, mucous membrane, ability to make tears, and urinary values), showing dehydration was assessed. "Also, with the patient's elevated heart rate in the setting of this illness, it would make most sense to attribute this to dehydration," which should have been listed as a diagnosis and required specific treatment with medication and hydration. Failure to list dehydration as a diagnosis represents a simple departure.

23. **Non-infectious Diagnosis.** Dr. Nageswaran found nothing in the medical chart to suggest a non-infectious cause for A.P.'s condition. In fact, the most common forms of gastroenteritis are viral, then bacterial and parasitic. Non-infectious causes of gastroenteritis have recurrent symptoms, caused by a food intolerance, starting a new medication known to cause stomach upset, or food poisoning. Non-infectious gastroenteritis is diagnosed based on a specific history. Respondent failed to document a diet history, to rule food poisoning in or out.

> [Ultimately, w]ith a typical acute presentation and without red flag symptoms or other specific history . . . an otherwise healthy patient presenting with sudden onset nausea, vomiting, and/or diarrhea would be diagnosed with acute gastroenteritis, presumed viral (and self-limited), unless there were reasons to consider otherwise.
>
> Diagnosing A.P. with acute gastroenteritis non-infectious is a simple departure from the standard of care.

Testing

24. **Orthostatic Vital Signs (OVS).** A diagnosis of dehydration can be confirmed with OVS, which requires heart rate and blood pressure readings in three

different positions – lying, sitting, and standing. Not taking OVS represents a simple departure.

25. **Urinary Tract Infection (UTI).** Low back pain, nausea, and vomiting are all symptoms commonly associated with pyelonephritis (kidney infection) as well as renal colic (pain from kidney stone). Pyelonephritis can also have a fever, weakness, fatigue, and other constitutional problems. Both of these diagnoses are ruled out or diagnosed using a routine urinary analysis.

> Despite UTIs being uncommon in young males without urinary symptoms, they can still happen. With this patient presenting with nausea, vomiting, and also elevated temperature in addition to severe low back pain, it would have been the standard of care to check his urine for signs of infection or kidney stones, even in the absence of urinary symptoms. That said, his gastrointestinal symptoms were much more classic for the more common diagnosis of acute gastroenteritis, so it is really the presence of the low back pain symptoms that would lead a one to consider these urological conditions as possible causes too. Not checking a [urinary analysis] with this particular clinical presentation (with the significant low back pain) represents an extreme departure.

26. **Blood Tests.** Blood tests help narrow down possible conditions a patient may have, help determine electrolyte abnormalities, hepatic causes to symptoms, renal involvement as a result of hydration status, as well as the extent of any infection that might be present. Blood tests are routinely performed on adults in the ED, because it is faster and easier to rule out major conditions. Blood tests are not always available in urgent care environments, so a doctor must determine whether it is appropriate to send a patient to the ED for blood tests. In this case, the clinic could have run some blood tests, and with a low-grade fever and very high heart rate,

suggesting dehydration or physiological distress, blood work should have been attempted and failure to do so was a simple departure from the standard of care.

Treatment

27. **Medication.** Toradol is a nonsteroidal anti-inflammatory drug (NSAID) well known to cause gastric upset. There are options other than Toradol for pain management in an urgent care setting. "[I]n the face of acute gastrointestinal disturbance (when resting and healing of the gastric lining is essential for the tolerance of oral intake and the overall recovery process), one would ordinarily try to avoid NSAIDs, especially in a strong dose (even in a large patient)." "Though there may be limited options for effectively treating this patient's significant back pain without the risk of other adverse events, in the setting of acute vomiting, the use of a high dose NSAID represents a simple departure.

28. Respondent also prescribed Zofran, with the expectation that A.P. would be able to rehydrate himself orally once he took the medicine. "However, besides the time needed to fill the prescription and ingest it (during which time the patient would have presumably been losing more fluids from his significant vomiting symptoms), it was not known if the patient would have been able to tolerate ingesting the medication itself, nor that it would be digested or absorbed." As such, Respondent should have monitored A.P. for oral fluid tolerance before discharge, especially given A.P.'s elevated heart rate (even if it were <120). Failure to conduct and monitor the oral fluid tolerance of A.P. prior to discharge represents a simple departure from the standard of care.

Discharge

29. **Patient Status/Repeat Vital Signs.** During his Board interview, Respondent stated that A.P. was "pretty uncomfortable" when he arrived at the clinic and was immediately taken back to be seen, and following the Toradol injection, Respondent stated that A.P. was looking better, stable, and walking around. Neither was documented in the medical chart; failure to document the clinical status on

admission is a simple departure and failure to document the improvement in clinical status prior to discharge is an extreme departure.

30. In addition, minutes after arrival, Respondent conducted a physical of A.P. and marked NAD (no acute distress) in the medical chart, suggesting a very different clinical status than "pretty uncomfortable." Also, Respondent did not document any improvement in A.P.'s clinical status before discharge. Doctors must watch patients, and document presentation and improvement in clinical status in the medical chart; the documentation corroborates the doctor's decision-making (e.g., discharge versus send to ED). Moreover, no repeat vitals where taken, leaving the medical chart absent of any final clinical status for A.P.

31. **Time with Patient.** Dr. Nageswaran found A.P.'s time in the clinic to be approximately 14 minutes, insufficient time to adequately assess and reassess A.P. The time stamp for patient check-in was 14 minutes before A.P. was given a Toradol injection, suggesting that the time between receptionist check-in, vital signs by MA Gill, physical examination and ordering treatment by Respondent, and injection by MA Gill was only 14 minutes total. Also, the discharge paperwork was printed at the same time the Toradol injection was administered and A.P. signed the discharge instruction acknowledgement sheet 10 minutes later, indicating that A.P. would have been observed, reevaluated, and released no more than eight to nine minutes after receiving the injection. For the amount of items claimed to have been done, and to adequately assess and reassess A.P., the time spent was insufficient and represented a simple departure.

32. **Discharge Instructions.** Dr. Nageswaran found the discharge instructions to be lacking, with no direction to seek further care if the patient's pain does not decrease and/or he continues to vomit, with the concern being dehydration. In addition, there is no direction to report to the ED if the problem worsens or new symptoms appear. The lack of more complete or relevant written discharge recommendations, especially with several concerning findings, represents a simple departure.

RESPONDENT EXPERT – JOHN (JACK) WOOD, D.O.

33. Dr. Wood completed a Bachelor of Art in accounting in 1971, at Luther College, Decorah, Iowa. He earned his Doctor of Osteopathy in 1976, from Des Moines University, College of Osteopathic Medicine. Dr. Wood then completed a one-year internship at Des Moines General Hospital, and then a two-year residency in emergency medicine at the Los Angeles County/University of Southern California Medical Center. In addition, he served in the United State Air Force, as a Major, from 1977 to 1984. In 1980, he became licensed to practice medicine in California. He is a Diplomate of the National Board of Medical Examiners for Osteopathic Medicine and Surgery, the American Board of Emergency Medicine (Board Certified 1983 to 2013), and the American Osteopathic Board of Emergency Medicine (Board Certified 1984 to present). He is also a Fellow of the American College of Emergency Physicians. Dr. Wood has treated patients in EDs for 39 years.

34. Currently, Dr. Wood is a physician in the ED at Mercy San Juan Medical Center. He handles both critical care patients, where the focus is on the immediate trauma or injury, and urgent care patients, where the focus is on triaging the chief complaints. He has seen thousands of patients in both critical and urgent care, and reviewed hundreds of urgent care medical records over his 39-year career. He is also the Medical Director for American Medical Response, National College of Technical Instruction (NCTI), and Yocha Dehe Fire Department, as well as a clinical professor at California Northstate University in Elk Grove, California. In addition, he is on the Quality Care Committee at Mercy San Juan, evaluating the care and treatment provided by Mercy doctors. Finally, Dr. Wood is an Oral Examiner for the Board. He has provided testimony in court and in deposition in civil matters, on behalf of the plaintiff only once.

35. Respondent retained Dr. Wood to conduct a review of documents and provide an opinion as to whether Respondent acted within the medical standard of care when he treated A.P. Dr. Wood reviewed the following documents: Respondent's Statement of Care (December 30, 2016) and letter to Board (March 28, 2018); medical

records for A.P. from Sutter Medical Center and Sacramento Urgent Care from August 10, through 12, 2016; Respondent's Board interview transcript; Dr. Nageswaran's Expert Report, addendums, and CV; the Board Investigative Report and Accusation; and A.R.'s and Respondent's civil deposition transcripts. On May 6, 2019, Dr. Wood drafted an Expert Report, finding Respondent made a single simple departure from the standard of care on one occasion in his care and treatment of A.P. Dr. Wood did note some deficiencies in medical recordkeeping, as discussed below. Dr. Wood testified at hearing consistent with his Report.

36. At hearing, Dr. Wood provided a review of the case, noting his opinions, and the basis upon which he made his findings. To evaluate Respondent's care and treatment of A.P., Dr. Wood compared it to how a reasonable or prudent doctor, in a Sacramento urgent care facility, who had the same or similar training, would treat a patient presenting with similar symptoms. For Dr. Wood, a simple departure from the standard of care is a minor deviation that does not affect the care and treatment of the patient, but an extreme departure is care that is out of the ordinary, something a reasonable or prudent doctor would not do, perform, or eliminate from the treatment plan.

37. In this case, Dr. Wood compared Respondent's care with the care and treatment appropriate for a patient presenting to a Sacramento urgent care environment with the same symptoms and presentation as A.P. More specifically, Dr. Wood addresses each issue/departure identified by Dr. Nageswaran, and he opined that Respondent engaged in one simple departure from the standard of care by failing to repeat A.P.'s vital signs before discharge.

Examination

38. **Medical History**. Dr. Wood found Respondent took a medical history of A.P. that complied with the standard of care The E/M or medical chart was complete with answers to queries relevant to an adequate medical history, including: main problem, date of onset, location, list of related symptoms, severity, quality, causation, associated circumstances if applicable, chronic/inactive conditions, medications,

surgeries, family history, substance use and allergies. In addition, Respondent evaluated A.P.'s heart rhythm, when he conducted a cardiovascular examination, finding normal results and no murmurs, rubs, gallops, or clicks. Dr. Wood noted that an abnormal sinus rhythm would have been documented in the medical chart, but not a normal sinus rhythm. Respondent found a heart rate of 120, which was not alarming given A.P.'s condition. This heart rate is not documented, and Respondent has no independent recollection of A.P.'s heart rate.

39. **Abnormal Vital Signs and Heart Examination**. Dr. Wood conceded, A.P. presented with abnormal vital signs. However, A.P. was an obese adolescent, presenting with complaints of nausea and vomiting, and appeared anxious and uncomfortable. Dr. Wood noted:

> It is extremely common for patients to present initially with elevated vital signs in this type of setting, and, after a brief period of time, the patient's vitals begin to normalize when they are settled in a more controlled and less threatening environment such as an examining room. It is also very common to have abnormal vitals when a patient is in pain and vomiting.

40. Following the initial vitals taken by MA Gill, Respondent conducted a physical examination of A.P. and listened to his heart. The E/M does not include a category for tachycardia, but given A.P.'s condition, an elevated blood pressure and tachycardic heart rate of 120, would not need to be noted. Dr. Wood noted that the Sutter ED made the same normal finding. Nonetheless, for Dr. Wood, failing to document A.P. was tachycardic constitutes a medical record documentation deficiency, not a deviation from the standard of care.

Diagnosis

41. **Dehydration.** Dr. Wood found Respondent's evaluation of A.P.'s hydration status, finding several relevant categories to be normal or negative, was

within the standard of care. Respondent conducted an ear, nose, and throat examination, with no findings of dry mucus membranes, dull or sunken eyes or dark circles below the eyes, pallor of the oral mucosa, or a lack of skin turgor. In addition, Respondent evaluated the cranial nerves (CN 2-12), which required Respondent to look in A.P.'s mouth to assess any asymmetric movement of the uvula, and found no dry mucus membranes. Finally, Respondent completed an abdominal examination of A.P. and did not note any diminished or absence of bowel sounds, a sign of dehydration. Dr. Wood noted that the Sutter ED made a finding of mildly dry mouth hours later.

42. **Non-infectious Diagnosis.** Dr. Wood agreed with the diagnosis of gastroenteritis non-infectious. Non-infectious gastroenteritis is a common inflammation of the gastrointestinal tract (acute gastroenteritis), food borne (food poisoning) or viral etiology (stomach flu). Infectious gastroenteritis usually applies to more serious gastrointestinal infections (e.g., Shigella, Salmonella, E. Coli), which can cause a more severe illness and spread to others with relatively close contact. In this case, no one else in A.P.'s family was ill, so the non-infectious label was appropriate. However, Dr. Wood would have wanted a history from A.P. of recently ingested foods to rule out food poisoning; Dr. Wood considers the failure to be a documentation deficiency.

Testing

43. **Orthostatic Vital Signs (OVS)**. Dr. Wood opined the standard of care did not require Respondent to take OVS from A.P. To test OVS, vital signs are taken from a patient to check coordination when moving, without feeling lightheaded or dizzy or a sensation of fainting or falling. Respondent noted in the medical chart, A.P. had normal gait and station, and could ambulate throughout the clinic; the OVS was unnecessary. In addition, A.P. was obese and in pain and taking OVS would have undoubtedly made him more uncomfortable. Finally, Dr. Wood referenced several journal articles, as well as his own personal experiences, finding OVS as an unreliable measurement for dehydration; he has not taken OVS for more than 15 years in the ED.

44. **Urinary Tract Infection (UTI).** Dr. Wood opined the standard of care did not require Respondent to test A.P. for a UTI. A.P. had a low-grade fever, consistent with gastroenteritis, not an infection. A.P. had low back pain, not in the costovertebral angle area where kidney discomfort would be appreciated. A.P. made no complaints of decreased urine output, dysuria, discolored urine, urethral discharge, hematuria, flank pain or polyuria. In addition, a male adolescent has such an extremely low index of suspicion for urinary related pathology, it was unnecessary to include a UTI in a differential diagnosis. With a chief complaint of back pain, most doctors would find a musculoskeletal etiology.

45. **Blood Tests.** Dr. Wood opined the standard of care did not require Respondent to order blood tests for A.P. Blood tests are not a routine procedure in urgent care environments, especially when no indication for them are present. With a diagnosis of gastritis with low back pain, blood tests were not indicated. Further, it is unnecessary to document in the medical chart reasons blood tests were not ordered. Finally, blood tests have to be sent out for analysis from the urgent care facility, with results returned in 24-72 hours; in general, blood tests are not practical in an urgent care environment.

Treatment

46. **Medication.** Dr. Wood found Respondent's diagnosis and treatment plan for A.P. to be within the standard of care. Respondent ordered a Toradol injection to reduce the pain; a commonly used NSAID to treat musculoskeletal pain or discomfort, with an uncommon potential to cause gastric upset. In addition, pain can often contribute to other symptoms, including nausea and vomiting. Dr. Wood frequently uses Toradol to treat patients with significant pain, along with nausea and vomiting, with excellent improvement in their discomfort and resolution of their nausea and vomiting as a result of the reduction in pain. Finally, the Toradol was effective in this case, because A.P. presented to the Sutter ED, a few hours later, with no complaints of back pain.

47. In addition, Respondent prescribed Zofran 8 mg ODT. Zofran is an anti-emetic medication appropriate to decrease nausea and vomiting. The oral dissolving tablet is placed under the tongue to dissolve without having to swallow the medication. In addition, A.P. was not actively vomiting upon discharge. Zofran was the appropriate medication to prescribe to A.P.

Discharge

48. **Patient Status/Repeat Vital Signs.** Dr. Wood found Respondent's documentation of A.P.'s status, was within the standard of care. On the E/M, Respondent marked NAD (no acute distress), meaning A.P. was not likely to become unstable in the next five minutes. The Sutter ED found A.P. to be NAD as well. However, the E/M does not include repeat vital signs before A.P was discharged. Typically, repeat vital signs are taken by nurses or medical assistants, and when abnormal, are reported to the treating doctor. In this case, MA Gill forgot to take repeat vitals of A.P. MA Gill did, however, check A.P.'s status after the Toradol injection and note the patient was "good." Nonetheless, Respondent is responsible for the care and treatment of A.P., including omissions by his staff. Dr. Wood found the failure to repeat vital signs a simple departure from the standard of care.

49. **Time with Patient.** Dr. Wood found A.P.'s time in the clinic to be approximately 27 minutes, sufficient for a history, physical examination, pharmaceutical intervention and reassessment. Dr. Wood noted that discharge instructions are almost always printed prior to actual patient discharge; on the assumption that the patient will get better with treatment. In this case, A.P. checked in about 1:54 p.m. His insurance was run at 1:56 p.m. and the E/M stickers were printed at 1:59 p.m. Between 2 and 2:12 p.m., MA Gill took vital signs and a medical history, then Respondent completed a physical examination and diagnosis. Then, Respondent directed MA Gill to give a Toradol injection. At approximately 2:13 p.m., A.P. was given a Toradol injection, and told to wait for 10 minutes. Also at 2:13 p.m., Respondent printed discharge instructions at the nursing station, and at 2:23 p.m., A.R. signed the discharge instructions acknowledgement form.

50. **Discharge Instruction.** Finally, A.R./A.P. were provided with discharge instructions for gastroenteritis and food poisoning, that complied with the standard of care. The discharge instructions included directions to "Get Prompt Medical Attention if any of the following symptoms occur," including "increasing abdominal pain or constant lower right abdominal pain, continued vomiting (unable to keep liquids down), frequent diarrhea (more than 5 times a day) . . . ." In addition, Respondent added, "Special Advice: back or go to the ER for worsening pain or fever."

51. In sum, Dr. Wood found Respondent did not commit an extreme departure from the standard of care in his evaluation, treatment and disposition of A.P. on August 10, 2016. Dr. Wood found one simple departure from the standard of care for failing to take repeat vitals of A.P. In addition, Dr. Wood indicated a need for improvement in Respondent's medical recordkeeping, but noted that Respondent has since taken the University of California, San Diego PACE (Physician Assessment and Clinical Education) Medical Recordkeeping course (April 2018).

Respondent

52. Since December 2016, Respondent has completed 57.5 hours of continuing education, in areas including: cardiology, cancer, breast cancer, vascular, atrial fibrillation, UTIs, renal failure, dyslipidemia, cognitive decline, palliative care, psoriasis, and medical recordkeeping at UC San Diego, PACE in April 2018. Respondent attended the PACE course to learn and improve his documentation. He appreciated the content and examples. He established a new baseline for good documentation and understands the legal implications thereof. He completed in-class exercises with oversight, and came away with a good understanding of the requirements for successful documentation.

53. Currently, Respondent is the Medical Director for Lincoln Medical Associates Inc., Sacramento Urgent Care Inc., Elk Grove Urgent Care Inc., Folsom Urgent Care Inc., and Davis Urgent Care Inc., providing direct patient care. In addition, Respondent teaches family medicine residents and physician assistant and nurse practitioner students. Respondent began opening urgent care clinics while working at

Sutter. He was struck by the congestion of patients in the ED; people traveling long distances for treatment of minor injuries; and the lack of urgent care facilities in the Sacramento area.

In 2008, with Allen Lin, M.D., another Sutter ED physician, Respondent opened the Elk Grove Urgent Care Clinic. In 2009, they opened the Sacramento Urgent Care Clinic on Florin Road. In 2010, the primary care physician (PCP) from Lincoln Medical Associates called Respondent and relayed his plans for retirement; he asked Respondent to buy his practice, serving 3,000 seniors near the SunCity senior community. Respondent bought the Lincoln practice. In 2012, the PCP from Freeport Medical Center called Respondent and relayed his terminal medical diagnosis; he asked Respondent to buy his practice, serving a Cantonese speaking, Chinese immigrant population of seniors. Respondent bought the Freeport practice, and maintained current patients until they found new PCPs; he took a financial loss on the business and closed the practice in 2017. Currently, Respondent works three to four days per week in Lincoln and sees 25 to 30 patients each week. He works at Sacramento Urgent Care and Elk Grove Urgent Care clinics five to seven days per month, seeing 40 to 50 patients. He employs and supervises a staff of 100 employees.

Respondent maintains the same Clinical Policies and Procedure Manual at each clinic, last updated on September 20, 2015. The Manual, under Triage and Initial Assessment of the Patient to the Urgent Care Center, includes the following mandate: "all abnormal vitals must be rechecked before discharge and must notify provider to be signed off." Respondent explained that in A.P.'s case, MA Gill did not follow the mandate as required. After the Board notified Respondent of the Consumer Complaint, he counseled MA Gill, and distributed a new one-page policy to all employees, for signature, stating:

> When we have a patient that has abnormal vitals, you must repeat the vitals prior to the patient's departure, and inform the Provider on staff of the vitals before the patient leaves. The Provider must sign off on the first as

> well as the second set of vitals. Vitals should be repeated if: Abnormal EKG, Low O2 stats, breathing treatment [ordered], high blood pressure, low blood pressure, injection for pain med, all abnormal vitals in general.

54. Respondent is also a civic-minded person. He volunteers with the Sacramento Job Corps, providing on the job training to low-income students. He sponsors the Elk Grove Police Activities League Boxing and Football teams, and provides free physicals to all athletes, as well as medical care during tournaments. He also repeatedly sponsors: Cosumnes Community Service District parks and recreation t-ball, Elk Grove Girls softball, Mateen Boxing Club West Sacramento tournament, Elk Grove Artists, Elk Grove Annual Pumpkin and Harvest festivals, UC Davis Annual Picnic Day, Celebrate Davis Day, Mercy Foundation Annual Golf Tournament, Elk Grove Annual Dickens Faire, Elk Grove Youth Sports Foundation "Home Run" Scholarship, Elk Grove Summer Farmer's Market, and Elk Grove Old Town Association Chili Cook-off, among others. In addition, Respondent donates to The Lord's Grace Chinese Church in Roseville, the Davis Police Association, and the Crocker Art Museum.

55. Respondent offered eight character letters from professional colleagues, patients, and community organizations: Jose Alberto Arevalo, M.D., Chief Medical Officer, Sutter Independent Physicians, 10 years; Joseph J. Jammal, M.D., cardiologist, 10 years; Ban Truong, D.O., 10 years; and Dr. Li, 12 years; patients Douglas W. Gongaware, Jr., nine years and Amy Tong, seven years; and May-Va Vang, Work Based Learning Coordinator, Sacramento Job Corps Center, and Fo Quang Shan Bodhi Temple. In sum, the letters describe Respondent as:

> a hardworking physician with great medical knowledge in clinical medicine, [who is] professional, caring [and] compassionate; [he] provide[s] the highest level of quality medical care; [is] a role model in the community

> [and] well-respected; [and he] continues to improve his health care delivery; patients love Dr. Li.

56. Each letter makes specific reference to an act of kindness initiated by Respondent, both professionally and in the community, personally. The letters all acknowledge the Accusation issued by the Board, dismissing it as uncharacteristic of Respondent; knowing Respondent to only provide the utmost in care to his patients. Dr. Lin and Ms. Tong also testified at hearing consistent with their letters.

57. Finally, in a statement to the Board, Respondent reflected:

> I am remorseful for what happened to this patient. I take my Hippocratic Oath very seriously not to do harm, and in my 20 plus year medical career, I have abided by that oath, and have tried to help my patients as much as I can. I have always kept up with my CME and I have been to PACE to improve my recordkeeping. I have been quite humbled by this incident and I will continue to look for ways to improve myself.

Discussion

58. Respondent has practiced emergency and urgent care medicine for 22 years. He has an unblemished medical record. At issue: Respondent's care and treatment of A.P., a 16-year-old adolescent, in a Sacramento urgent care environment, presenting with low back pain, nausea, vomiting, and diarrhea for three days. The standard of care in an urgent care environment is treatment for specific complaints or symptoms, not for diagnostic evaluation of chronic medical conditions, such as diabetes.

At Sacramento Urgent Care Clinic, MA Gill took a medical history and vital signs, Respondent conducted a focused physical examination, and A.P. was treated with a Toradol 60 mg. injection for low back pain and a prescription for Zofran 8 mg.

ODT for the nausea and vomiting. He was observed for 10 minutes following the injection, then released. He was given discharge instructions for gastroenteritis and food poisoning, with detailed information, including the direction to go to the ED if symptoms worsened.

59. The Board offered Dr. Nageswaran to evaluate Respondent's care and treatment of A.P. Dr. Nageswaran has practiced medicine for 16 years, emergency medicine for two years and urgent care medicine for six years at four different clinics. She left the urgent care environments after becoming frustrated with management and the limited time allocated to each patient. She is familiar with the E/M used by Sacramento Urgent Care. She has used the same form, and believes simply checking boxes on the E/M is insufficient for adequate medical recordkeeping.

60. Dr. Nageswaran evaluated Respondent's care and treatment of A.P. and wrote a Report. Dr. Nageswaran's Report was lengthy. She divided the care and treatment of A.P. into subcategories, sometimes finding the same act to be negligent on multiple occasions. She faulted Respondent for failing to document or provide information that was in fact contained in the E/M and discharge instructions. She dismissed Respondent's normal/negative findings, because he simply checked boxes on the E/M and did not write out the same (e.g., found Respondent failed to evaluate A.P. for dehydration, but Respondent checked boxes indicating a normal examination of his ears, nose, and throat, skin, and cranial nerves). She rejected the sufficiency of Respondent's documentation of patient status – pain/discomfort 10/10; instead, insisting specific language should have been included – "uncomfortable."

61. Dr. Wood has practiced emergency and urgent care medicine for 39 years. He is a seasoned veteran of the environment, and has experience evaluating doctors' quality of care. Dr. Wood found Respondent committed one simple departure from the standard of care and two documentation errors. Dr. Wood believes Respondent has addressed his documentation issues by attending the PACE course, and he found, in sum, Respondent practiced within the standard of care in his care and treatment of A.P.

62. Dr. Wood also has extensive experience in medical quality assurance evaluation, but has never evaluated cases for the Board, while Dr. Nageswaran has only evaluated cases for the Board. Dr. Wood conducts Board oral examinations, evaluating fledgling doctors, and has testified numerous times; Dr. Nageswaran has not. At hearing, Dr. Wood provided specific references to the E/M to support his opinions; Dr. Nageswaran pointed to her Report, which was written based on review of the records.

63. Relying on some but not all of an expert's opinions may be entirely appropriate. "It is well settled that the trier of fact may accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal. 3d 51, 67.) The trier of fact may also "'reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected available material.'" (*Id.* at pp. 67-68) Furthermore, the fact finder may also reject the testimony of a witness, even an expert, although it is not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal. 3d 875, 890.)

LEGAL CONCLUSIONS

Standard of Proof

1. To revoke or suspend Respondent's medical license, complainant must establish the allegations and violations alleged in the Accusation by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The requirement to produce clear and convincing evidence is a heavy burden, far in excess of the preponderance of evidence standard that is sufficient in most civil litigation. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating

assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Purpose of Discipline

2. The purpose of the Medical Practice Act[2] is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App. 3d 564, 574.) The imposition of license discipline does not depend on whether patients were injured by unprofessional medical practices. (See, *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d. 1471; *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Our courts have long held that the purpose of physician discipline by the Board is not penal but to "protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from ignorance or incompetency or a lack of honesty and integrity." (*Furnish v. Board of Medical Examiners* (1957) 149 Cal.App.2d 326, 331.

Applicable Laws

3. Business and Professions Code section 2234 requires the Board to "take action against any licensee who is charged with unprofessional conduct." "Unprofessional conduct includes, but is not limited to: gross negligence and repeated negligent acts." (Bus. & Prof. Code, § 2234, subds. (b) & (c).) "To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable

[2] Business and Professions Code sections 2000, et seq.

standard of care shall constitute repeated negligent acts." (Bus. & Prof. Code, § 2234, subd. (c).)

4. In addition, Business and Professions Code section 2266 states: "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

Cause for Discipline

5. Cause does not exist for disciplinary action under Business and Professions Code section 2234, subdivision (b), by reason of the matters set forth in the Factual Findings 6-63. Complainant did not prove by clear and convincing evidence that Respondent engaged in gross negligence in his care and treatment of A.P.

6. Cause does not exist for disciplinary action under Business and Professions Code section 2234, subdivision (c), by reason of the matters set forth in the Factual Findings 6-63. Complainant did not prove by clear and convincing evidence that Respondent engaged in repeatedly negligent acts in his care and treatment of A.P.

7. Cause exists for disciplinary action under Business and Professions Code section 2266, by reason of the matters set forth in the Factual Findings 6-63. Complainant proved by clear and convincing evidence Respondent failed to maintain adequate and accurate records for A.P. on August 10, 2016.

Level of Discipline

8. Considering the Factual Findings and Legal Conclusions, discipline is warranted in this case for public protection based on Respondent's failure to maintain adequate and accurate medical records, which is unprofessional conduct under Business and Professions Code section 2266.

The Board's *Manual of Model Disciplinary Orders and Disciplinary Guidelines* (12th Edition, 2016) (Disciplinary Guidelines) recommends five years' probation as the minimum level of discipline for a violation of Business and Professions Code section 2266, in addition to various terms and conditions. Departure from the Disciplinary Guidelines is warranted here, however, after taking the following into consideration: This case involved a single patient; Respondent had no prior disciplinary action against his certificate; and Respondent has expressed remorse for the deficiencies in this case, acknowledged there is room for improvement, and has taken steps on his own to begin remediation. Respondent has attended a PACE Medical Recordkeeping class, which provided him a refresher course and refocused him on recordkeeping as a priority, along with his care and treatment of patients. Consequently, deviation from the Disciplinary Guidelines is appropriate in this matter, and a public reprimand is sufficient to protect the public.

ORDER

Certificate No. A 87986 issued to Respondent Quinn Li, M.D., is hereby publicly reprimanded for unprofessional conduct pursuant to Business and Professions Code section 2266 for failing to maintain adequate and accurate medical records.

The Decision shall become effective at 5:00 p.m. on August 19, 2022.

IT IS SO ORDERED this 20th day of July, 2022.

Laurie Rose Lubiano, J.D.
Chair, Panel A
Medical Board of California

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STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO April 10, 2018
BY: ANALYST

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

In the Matter of the Accusation Against: **Quinn Li, M.D.** **841 Sterling Pkwy Ste 120** **Lincoln, CA 95648-7324** **Physician's and Surgeon's Certificate No. A 87986,** Respondent.	Case No. 800-2016-028347 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about July 1, 2004, the Medical Board issued Physician's and Surgeon's Certificate Number A 87986 to Quinn Li, 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 July 31, 2018, unless renewed.

JURISDICTION

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

4. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

"...."

5. 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."

STATEMENT OF FACTS

6. On August 10, 2016, patient A.P.[1], age 16, went to the Sacramento Urgent Care Clinic with his mother, seeking treatment for back pain, nausea, vomiting, and diarrhea. A.P. officially checked into the clinic at 1:59 p.m. Sacramento Urgent Care staff, and Respondent found that A.P.'s vital signs were all abnormal—he had a low grade fever, very elevated heart rate high blood pressure, and elevated breathing rate. The clinic record notes that A.P. was uncomfortable due to his nausea and vomiting. Respondent diagnosed A.P. with back pain, nausea and vomiting due to gastroenteritis. Respondent ordered an injection of Toradol, a pain medication, to treat Respondent's back pain and prescribed an oral anti-emetic medicine to counter the vomiting.

7. Respondent did not document in the Urgent Care Clinic records that A.P. was obese. Respondent did not take a past medical history or family medical history, and did not document his observations about A.P.'s condition.

8. In addition, Respondent incorrectly noted in the chart that A.P.'s heart examination was normal, when in fact, A.P. had an extremely elevated heart rate, in the 140's range. A normal heartbeat for a teenager A.P.'s age would be 60-100. Respondent did not document whether A.P. had a lower heart rate any time during the time he was in the clinic. Respondent did not consider the possible causes of this high heart rate, and did not document any changes in A.P.'s rapid heart beat, or whether the rhythm—a separate vital sign from the rate-- was normal. Furthermore, A.P. presented with symptoms concerning for dehydration, but Respondent failed to document A.P.'s hydration status on physical examination.

9. Despite the fact that A.P. presented with elevated temperature, significant low back pain, nausea and vomiting, Respondent did not order any urinalysis. Nor did Respondent order any diagnostic blood tests for A.P. Respondent furthermore did not document whether he or any other staff at Sacramento Urgent care checked to see whether A.P. was able to tolerate fluids, or whether he was in need of IV fluids. And, Toradol, the pain medicine injection that Respondent

[1] To preserve patient confidentiality, the subject patient is referred to herein as A.P. The patient's full name is known to Respondent.

ordered for A.P., causes gastric upset—a fact that Respondent ignored or overlooked in his treatment of A.P.

10. Respondent noted that A.P. generally appeared to have improved after the Toradol injection, but Respondent did not document any specific improvement in A.P.'s vital signs, before sending him home. Respondent diagnosed A.P. with "gastro-enteritis, non-infectious" but did not take an adequate history to make a diagnosis about the cause of A.P.'s vomiting—such as whether it was viral, bacterial, or resulted from something he ate, or other possible cause. And, Respondent did not include any diagnosis for dehydration, even though A.P.'s vital signs pointed to dehydration as a diagnosis.

11. A.P. and his mother received discharge instructions 14 minutes after they checked in at the front desk. Thus, according to the chart, Respondent did not take adequate time to fully assess and reassess A.P.'s symptoms. Respondent issued discharge instructions to A.P. that did not advise him what to do if his pain persisted, or if he had further vomiting. The discharge instructions contained only a generic disclaimer to return or consult a physician "if your problem worsens or you new symptoms appear . . . ."

12. Around 9 hours after Respondent discharged A.P. from the Sacramento Urgent Care Clinic, A.P.'s mother took him to the Sutter Medical Center Emergency Room. Sutter admitted A.P. to the Pediatric Intensive Care Unit, where he was found to have significant diabetic ketoacidosis, due to Type 1 diabetes, and pancreatitis. A.P. thereafter suffered multiple organ failures, and died on December 12, 2016.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence and Repeated Negligent Acts)

(Code Sections 2234(b)and (c))

13. Respondent Quinn Li, M.D. is subject to disciplinary action under section 2234(b) and 2234(c) in that Respondent's actions and omissions in the course of his care of A.P., as set forth in paragraphs 6-12, above, comprise gross negligence and/or repeated negligent acts in the course of his care of A.P., as set forth in paragraphs 6-12. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject to discipline pursuant to sections 2234 and/or

2234(b) and/or 2234(c) based upon his negligent care and treatment of Patient A.P., including but not limited to the following:

A. Respondent failed to include appropriate documentation in A.P.'s medical record, given the acute nature of A.P.'s presentation with multiple abnormal vital signs.

B. Respondent documented the abnormal vital sign of a heart rate of 140, but Respondent claimed during his later interview that A.P.'s heart rate was much lower during his heart exam. Respondent also claimed that A.P.'s slightly elevated body temperature interfered with the accurate measurement of A.P.'s heart rate, but Respondent did not repeat the measurement of the heart rate, or document any different results; and, a slightly elevated body temperature does not interfere with accurate measurement of a patient's heart rate.

C. Respondent documented that A.P. had a normal heart examination, when in fact., A.P.'s heart rate was well above normal.

D. Respondent presented with symptoms that were concerning for dehydration, but Respondent did not take note of A.P.'s hydration status.

E. Respondent did not take an adequate medical history for a patient who presented with a heart rate of 140, and did not evaluate whether A.P.'s heart rhythm was a normal sinus rhythm, or an abnormal rhythm.

F. Even though A.P. presented with an elevated heart rate and signs of dehydration, Respondent did not evaluate A.P.'s orthostatic vital signs—taking the same vital signs in sitting, standing and lying down positions-- which would have provided additional clinical information to evaluate A.P.'s condition. Orthostatic vital signs disclose a pattern, in that heart rate and blood pressure will change when the patient changes position, if the patient is dehydrated. Respondent should have measured A.P.'s orthostatic vital signs given A.P.'s clinical presentation of elevated heart rate and signs of dehydration.

G. A.P. presented with elevated temperature, low back pain, nausea and vomiting. Given these symptoms, Respondent should have checked for a Urinary Tract Infection. Respondent did not check A.P. for a urinary tract infection.

H. Respondent did not document any reasons why he did not order blood tests for A.P.

I. Respondent prescribed anti-emetic medication, but did not check whether A.P. was able to tolerate oral fluids, or that he was able to tolerate ingesting the medication; nor did Respondent adequately document any instructions to this minor patient and his mother that they should go to the Emergency Room if A.P.'s fever, vomiting and back pain symptoms did not improve.

J. Respondent treated A.P.'s back pain with an injection of Toradol, even though A.P. was experiencing gastric upset, and Toradol, even when injected, can cause gastric upset.

K. Respondent charted that the A.P. was both "uncomfortable" and "NAD" (not in acute distress.) Respondent did not adequately document the clinical status of A.P.'s discomfort, and did not document any improvement in this vital sign before sending him home.

L. Respondent diagnosed A.P. as having "acute gastro-enteritis, non-infectious" but did not document any history regarding potential infectious or non-infectious causes of A.P.'s illness, and omitted a diagnosis of dehydration.

M. Given that A.P.'s discharge instructions were printed around 14 minutes after A.P. checked in at the front desk, Respondent did not take sufficient time to adequately assess and reassess A.P. before sending A.P. home from the clinic.

N. Respondent did not give A.P. and his mother adequate, relevant discharge instructions, in the face of very concerning symptoms, in a patient who did not spend a very long time in the clinic.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

(Code Section 2266)

14. Respondent Quinn Li, M.D. is subject to disciplinary action under section 2266 in that the facts and circumstances described in paragraphs 6-13 above, reflect that Respondent failed to maintain adequate and accurate medical records as required by law.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 87986, issued to Quinn Li, M.D.;

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

3. Ordering Quinn Li, 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: April 10, 2018

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

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