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

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| **In the Matter of the First Amended Accusation Against:**<br><br>**Pramod Multani, M.D.**<br><br>**Physician's and Surgeon's Certificate No. A 38056**<br><br>**Respondent.** | **Case No.: 800-2017-030467** |

## DECISION

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

**This Decision shall become effective at 5:00 p.m. on March 16, 2023.**

**IT IS SO ORDERED: February 14, 2023.**

**MEDICAL BOARD OF CALIFORNIA**

**Richard E. Thorp, M.D., Chair**
**Panel B**

ROB BONTA
Attorney General of California
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*Attorneys for Complainant*

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

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| In the Matter of the First Amended Accusation Against:<br><br>**PRAMOD MULTANI, M.D.**<br>**12214 Lakewood Blvd., Suite 110**<br>**Downey, CA 90242-2662**<br><br>**Physician's and Surgeon's Certificate No. A 38056,**<br><br>Respondent. | Case No. 800-2017-030467<br><br>OAH No. 2020060911.1<br><br>**STIPULATED SETTLEMENT AND DISCIPLINARY ORDER** |

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

**PARTIES**

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

2. Respondent Pramod Multani, M.D. (Respondent) is represented in this proceeding by attorney Gregory D. Werre, whose address is: Reback, McAndrews & Blessey, LLP, 1230 Rosecrans Avenue, Suite 450, Manhattan Beach, CA 90266.

3. On or about February 22, 1982, the Board issued Physician's and Surgeon's Certificate No. A 38056 to Pramod Multani, M.D. (Respondent). The Physician's and Surgeon's

Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2017-030467, and will expire on June 30, 2023, unless renewed.

## JURISDICTION

4. First Amended Accusation No. 800-2017-030467 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of First Amended Accusation No. 800-2017-030467 is attached as Exhibit A and incorporated herein by reference.

## ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2017-030467. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

## CULPABILITY

9. Respondent understands and agrees that the charges and allegations in First Amended Accusation No. 800-2017-030467, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in First Amended Accusation

No. 800-2017-030467, and that Respondent hereby gives up his right to contest those charges.

10. Notwithstanding anything to the contrary contained herein, Respondent admits that he failed to adequately document his decision making and conversations with Patient A relating to her refusal to receive treatment for her deteriorating kidney functioning and the decision that she be placed in hospice, in violation of Business and Professions Code section 2266.

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

## CONTINGENCY

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

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in First Amended Accusation No. 800-2017-030467 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

14. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-entitled matter.

15. The parties understand and agree that Portable Document Format (PDF) and facsimile

copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

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

**DISCIPLINARY ORDER**

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 38056 issued to Respondent PRAMOD MULTANI, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 60 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 85 hours of CME of which 60 hours were in satisfaction of this condition.

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

A medical record keeping course taken after the acts that gave rise to the charges in the First Amended 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 First Amended 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 three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

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

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

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical

competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

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

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

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

6. PROHIBITIONS ON PRACTICE. Respondent shall have the following restrictions on his medical practice:

(A) Respondent is prohibited from practicing medicine within the same premises, including, without limitation, any building, where Anju Multani (his spouse) practices law.

(B) Respondent is prohibited from recommending, prescribing, and/or ordering any patient into hospice care ("Hospice Order") unless the following conditions are met:

(i) Respondent must physically evaluate the patient through a face-to-face visit and

prepare a written certification on the date of such evaluation which includes:

(a) a statement that the patient has a medical prognosis of 6 months or less if the terminal illness runs its normal course; and

(b) a brief narrative statement that includes patient-specific clinical findings and other documentation supporting a life expectancy of 6 months or less (e.g., signs, symptoms, laboratory testing, weights, anthropomorphic measurements, oral intake) and Respondent's rationale for his Hospice Order;

(ii) Respondent must obtain a documented informed consent from the patient, and the patient must acknowledge in writing that the patient accepts hospice and comfort care (palliative care) instead of treatment for any terminal illness and related conditions; and

(iii) Respondent must document that a second physician and surgeon (the patient's primary care physician, if the patient has a primary care physician) has physically evaluated the patient through a face-to-face visit, and that second physician and surgeon must certify in writing that the patient is terminally ill (with a life expectancy of 6 months or less).

After the effective date of this Decision, all patients being treated by the Respondent and who are (a) to his knowledge, current or former clients of his spouse, and/or (b) patients who are likely to become hospice patients within six months, shall be notified that the Respondent is subject to these conditions of prohibited practice. Any new patients, who are (a) to his knowledge, current or former clients of his spouse, and/or (b) patients who are likely to become hospice patients in within six months, must be provided this notification at the time of their initial appointment. Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the

Respondent shall provide a true copy of this Decision and First Amended 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. 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.

9. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, in the amount of $64,000 (sixty-four thousand dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by Respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by Respondent shall not relieve respondent of the responsibility to repay investigation and enforcement costs.

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

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

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and

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

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards'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 a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

14. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. This term does not include cost recovery, which is due within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board and timely satisfied. Upon successful completion of probation, Respondent's certificate shall be fully restored.

15. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

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

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

18. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in First Amended Accusation No. 800-2017-030467 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

## ACCEPTANCE

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

DATED: 9/22/2022

PRAMOD MULTANI, M.D.
*Respondent*

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

DATED: 9/22/22

GREGORY D. WERRE
*Attorney for Respondent*

## ENDORSEMENT

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

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California

Edward Kim Digitally signed by Edward Kim Date: 2022.09.26 20:48:09 -07'00'

EDWARD KIM
Supervising Deputy Attorney General
*Attorneys for Complainant*

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**BEFORE THE**
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| In the Matter of the First Amended Accusation Against:<br><br>**PRAMOD MULTANI, M.D.**<br>**11480 Brookshire Avenue, Suite 204**<br>**Downey, CA 90241-5018**<br><br>**Physician's and Surgeon's Certificate No. A 38056,**<br><br>Respondent. | Case No. 800-2017-030467<br><br>**FIRST AMENDED ACCUSATION** |

## PARTIES

1. William Prasifka (Complainant) brings this First Amended Accusation (hereinafter, "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 February 22, 1982, the Medical Board issued Physician's and Surgeon's Certificate Number A 38056 to Pramod Multani, 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.

## JURISDICTION

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

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

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> (d) Incompetence.
>
> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
>
> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

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## FACTUAL ALLEGATIONS

7. The Board received a complaint from the grandchild of Patient A,[1] an 88-year-old elderly woman who died on January 20, 2016 after Respondent took over her medical care, which had formerly been provided by another medical group for many years. The complaint alleged that Respondent's wife is a lawyer whose office is a converted patient room at Respondent's medical practice, that they share a receptionist, and that she had to expend significant resources to regain control of Patient A's estate from Respondent's spouse, A.M., who is an attorney. The complaint further alleged that during the month prior to her death, Patient A was in relatively good health, but somehow she had been placed under hospice care in or around December 2015 where she received a fentanyl patch, oral morphine and Ativan, even though she had been an opiate naive person.

8. Respondent first saw Patient A on or about July 17, 2015. She had been receiving medical services from Memorial Cardiology Medical Group for many years with a different cardiologist. Patient A's multiple medical conditions included:[2] severe mitral regurgitation; severe tricuspid regurgitation; hypertension; implanting of a Medtronic pacemaker on or about May 8, 2012; chronic atrial fibrillation; a history of Coumadin[3] use (for anticoagulation for stroke prevention in light of atrial fibrillation which carries a significant risk of stroke and embolism); chronic anemia; thrombocytopenia (low platelets) treated with IV romiplostim (Nplate) weekly infusions; chronic recurring leg edema treated with diuretics; hypertension treated with Benicar, amlodipine and Lasix; coronary artery disease; and a diagnosis of peripheral artery disease.

9. At that first visit with Respondent, Patient A's complaints included hypertension and dizziness. However, Respondent's chart entry for history of present illness was blank. Further, there was no description of dizziness in the chart for that day. There was no narrative regarding her past medical history. An EKG revealed a paced rhythm. There was no narrative assessment

[1] The patients are designated by letters to address privacy concerns. The identity of the patients is known to the Respondent.

[2] As used herein, including or included means, including, without limitation.

[3] Coumadin is a trade name for warfarin which is a medication that is used as an anticoagulant (blood thinner). It is commonly used to treat blood clots such as deep vein thrombosis and pulmonary embolism and to prevent stroke in people who have atrial fibrillation, valvular heart disease or artificial heart valves.

either. Respondent's plan included ordering a CT of the brain, carotid Doppler study and echocardiogram.

10. A CT scan of Patient A's brain was performed on or about July 28, 2015. It revealed moderate cerebral atrophy, small remote left basal ganglia lacunar infarct (prior stroke) and mild to moderate left parieto-occipital encephalomalacia compatible with residual/remote cerebral infarction (prior stroke). The report of the CT of the patient's head, dated July 30, 2015, included handwritten notes as "discussed" on September 10, 2015.

11. Lab results for a sample dated August 28, 2015, included: HCT of 28.6 with platelets 134,000, BUN of 62 and creatinine: 1.4 with potassium 4.7, an HBA1c of 5.3 and LDL cholesterol of 57, and TSH of 0.31. A note written on the lab results page stated that the patient must see an endocrinologist.

12. A letter dated September 10, 2015, addressed to Patient A informed her to reduce the furosemide (Lasix) from 40 mg to 20 mg a day. A note also told Patient A about an upcoming appointment with Respondent on September 15th along with scheduling a carotid Doppler study and echocardiogram on September 23, 2015.

13. On or about September 14, 2015, Respondent saw Patient A again. There was a handwritten note and typed note. The chief complaint and history section only listed hypertension. The documentation failed to contain any information regarding symptoms or test results. Medications listed were metoprolol tartrate 50 mg a day, metolazone 5 mg at bedtime, Benicar 40 mg once a day prn, clonidine 0.1 mg once daily for BP greater than 160/95, Lyrica 75 mg three times a day, warfarin 2.5 mg a day, amlodipine 5 mg a day, furosemide 40 mg a day, glipizide 2.5 mg a day and Lopressor 50 mg a day. The assessment portion of the chart listed anemia, non-insulin-dependent diabetes mellitus (NIDDM), hyperlipidemia, hypertension, warfarin therapy, and pacemaker. There was no narrative describing the assessment. The plan was for further labwork, including[4] CBC, CMP and uric acid. Edema and murmur were noted on the handwritten note but not typed note.

14. Lab results for a sample dated September 14, 2015, included: HCT of 29.2 and

[4] As used herein, including means, including without limitation.

platelets 105,000, Bun of 27 and creatinine of 1.1 with potassium 4.3.

15. On or about September 23, 2015, the patient underwent a carotid Doppler study which revealed carotid stenosis. On or about September 23, 2015, the patient underwent an echocardiogram which revealed normal left ventricular systolic function with moderate mitral regurgitation and mild pulmonary hypertension.

16. Patient A's September 25, 2015, medication list, included amlodipine, digoxin, metoprolol, Benicar, Ambien, Lasix, KCL. A urinalysis, dated the same date revealed two plus leukocytes.

17. On or about November 5, 2015 Patient A was seen in urgent care for urinary tract infection, wheezing and edema. Macrobid was prescribed as well as ProAir inhaler. Nebulizer was given during visit.

18. On or about November 6, 2015, Respondent saw Patient A, who had a history listing only dyspnea and edema. Medication listed was metoprolol tartrate 50 mg a day, metolazone 5 mg at bedtime, Benicar 40 mg once a day pm, clonidine 0.1mg once daily for BP greater than 160/95, Lyrica 75 mg three times a day, warfarin 2.5 mg a day, amlodipine 5 mg a day, furosemide 40 mg a day, glipizide 2.5 mg a day and Lopressor 50 mg a day. The assessment included shortness of breath, chronic anemia, chronic NIDDM, hyperlipidemia, chronic hypertension, warfarin therapy, chronic pacemaker. The plan included CBC, CMP and PT/INR next visit, double Lasix and potassium, check daily weights and pm to PIH Downey ER.

19. On or about November 11, 2015, Patient A's medication list included amlodipine, digoxin, metoprolol, Benicar, Ambien, Lasix, and KCL. On or about November 12, 2015, a swallowing evaluation from November 10, 2015 was faxed for dysphagia.

20. On or about November 18, 2015, the patient had prescriptions for Levaquin 500 mg a day for 7 days, KCL, and her medication list included metoprolol succinate, Benicar, levothyroxine, digoxin and HCTZ.

21. On or about November 18, 2015, lab results were as follows: HCT of 29.9 and platelets 60,000, BUN of 61, creatinine of 2.6, potassium of 6.1, and INR of 1.16.

22. On or about November 20, 2015, the patient received a swallowing evaluation due to

coughing with liquids and difficulty in swallowing.

23. On or about November 21, 2015, Respondent ordered a physical therapy evaluation and follow-ups due to decreased endurance, decreased balance and coordination.

24. On or about November 21, 2015, Respondent received a request to sign videoflouroscopic study and sign for recommendations and summary from PIH-Downey Outpatient Rehabilitation Department.

25. On or about December 1, 2015, Respondent faxed a request for records from Dr. W., the patient's former cardiologist.

26. On or about December 1, 2015, Respondent's nurse practitioner L, saw the patient, and noted worsening leg edema for 2-3 months. No shortness of breath was noted. BMP was ordered, the plan was to follow up in one month.

27. On or about December 2, 2015, labs results showed BUN of 61, creatinine of 1.75 and potassium of 5.4, HbA1c of 5.6, Uric Acid of 11.3, and vitamin D of 28ng/ml.

28. On or about December 7, 2015, an order was made for hematology/oncology consultation to evaluate thrombocytopenia, anemia and myelodysplastic syndrome.

29. On or about December 8, 2015, Respondent's nurse practitioner L. saw the patient again. Patient A was noted to have pacer checked with normal function. She had underlying atrial fibrillation in VVIR mode. Patient A was also having difficulty with urination for 2-3 weeks. Three plus edema was noted on examination. The patient's written list of medications included: amlodipine, digoxin, metoprolol succinate, Benicar, Lasix, KCL, allopurinol, and Bactrim DS.

30. The patient's Medtronic pacemaker was interrogated on or about December 8, 2015 in VVIR Mode and the lower rate was 75 bpm.

31. On or about December 8, 2015, urinalysis results showed greater than 100 WBCS and culture showed E-coli growth. The culture was resistant to Bactrim. Bactrim was stopped and Levaquin 500 mg was referenced but the documentation is unclear.

32. On or about December 21, 2015, labs results showed HCT 31.1 and platelets count was 44,000.

33. On or about December 15, 2015, 28 pages of Patient A's medical records were received from Dr. W. (patient's prior Cardiologist), via fax.

34. On or about December 16, 2015, labs results showed HCT of 29.1 with of platelets 93,000 and the note was "stable" as of December 17, 2015.

35. On or about December 18, 2015, Respondent saw Patient A with complaints of dyspnea and edema. The medications listed in his note included, metoprolol tartrate, metolazone, Benicar, clonidine, Lyrica, warfarin, amlodipine, furosemide, glipizide and Lopressor. The assessment showed a shortness of breath and the plan included a CBC, CMP and home nurse follow-up. The other assessment was chronic anemia, NIDDM, chronic hyperlipidemia, chronic hypertension, warfarin therapy patient, chronic pacemaker and CHF. He also noted that amlodipine was discontinued and HCTZ started. Levothyroxine, digoxin, metoprolol and KCL were refilled. Oxygen saturation was noted at 86% and Oxygen 2 liters was ordered.

36. On or about December 23, 2015, lab results showed that HCT of 31.3, platelets of 172, potassium of 6.0, BUN of 94 and creatinine of 3.6, and BNP of 828. Labs were noted as "stable" as of December 29, 2015.

37. On or about December 23, 2015, Lincare indicated that home oxygen was prescribed due to congestive heart failure ("CHF") and low oxygen saturation of 86%. An order of medical necessity was signed by Respondent on or about January 6, 2015.

38. On or about December 31, 2015, Respondent allegedly had a telephone conversation with Patient A, during which an alleged decision was made for Patient A to undergo a hospice evaluation. An order to Sunset Hospice care, dated December 31, 2015 was made, and home health with Rae Star Health systems was terminated. An order with a written certification was prepared, indicating that Patient A had a terminal illness and a life expectancy of six months or less.

39. On or about December 31, 2015, Sunset Hospice evaluated Patient A. At that time her medication included: Tylenol, Colace, Lasix, KCL, digoxin, levothyroxine, metoprolol succinate, Benicar, HCTZ, Duoneb, Lumigan and Alphagan eye drops for glaucoma.

40. On or about January 20, 2016, Patient A expired. A private autopsy performed by

another doctor noted that Patient A had severe arteriosclerosis, emphysema and cirrhosis.

41. On or about March 26, 2019, a Department of Consumer Affairs investigator and medical consultant conducted a subject interview ("SI") of Respondent on behalf of the Board, during which he made many conflicting statements and provided information that was not documented in the patient's medical record. He described how Patient A began treatment with him. He stated that her prior cardiologist, Dr. W. had some health issues and retired. And, that she was looking for another cardiologist and that another patient recommended that she come to see him. He described that Patient A "was a lovely lady, very elegant . . . very smart, very knowledgeable." In addition, he described Patient A as mentally sharp, "very, very sharp, extremely sharp." He also stated that his office switched to electronic record keeping in or around the third quarter of 2015.

42. In fact, Dr. W. did not retire. Moreover, Respondent's wife who shares an office space with the Respondent saw Patient A, on or about April 21, 2015, in connection with revising Patient A's estate plan. Further, Respondent's medical records contain Patient A's new patient information sheet signed by the patient on July 15, 2015, which lists Respondent's wife at 8333 Iowa Street, Suite 201, Downey, CA 90241, under the patient's "Spouse/Emergency Contact Info." Curiously, despite Dr. W.'s alleged retirement, Respondent requested medical records from his office on or about December 1, 2015, nearly nine months after his alleged retirement.

43. During his SI, Respondent incredulously stated that he did not know that his wife's employee, R.A.[5] ("Paralegal") was a caregiver for Patient A at her home until after Patient A had passed away and litigation ensued from Patient A's family who sought to gain back control of Patient A's estate. Respondent's wife had made an unsuccessful attempt to obtain control of Patient A's estate through conservatorship.

44. On or about June 18, 2018, Respondent stated at a deposition (the "June 18 Depo"), that Paralegal had stopped working for him in or around 2003.

[5] Paralegal had been Respondent's former employee (assistant billing manager) which he estimated was about 15 years prior to the then current date. In addition, Paralegal was previously convicted in 2003 of grand theft and forgery and also she suffered a civil judgment in 2002 in connection with a complaint alleging embezzlement of funds through check forgery and credit card use in an amount over $107,000.

45. Paralegal's name appears throughout Respondent's medical chart for Patient A, including on a faxed order for a swallow evaluation, dated November 10, 2005 from Paralegal; on physician orders, dated November 25, 2015 and December 31, 2015; on correspondence relating to a prescription, dated November 16, 2016; and on a faxed request for records to another provider, dated July 27, 2015.[6] This was despite the fact that he stated that Paralegal did not do any medical services, was not a certified medical assistant, and was unlicensed. Respondent stated that Paralegal's only role was in providing billing services.

46. Unbelievably, Respondent also stated that he did not know about his wife's legal maneuverings over Patient A's estate until after the aforesaid litigation. When asked, "how does [Paralegal] have time to function as a caregiver for somebody like Patient A when she's working full time for [Respondent's] wife," Respondent replied, "You know, from what I understand, she used to do it in the evening, after work." In addition to being involved with Patient A's medical care, Paralegal allegedly used Patient A's credit card and received checks from Patient A's bank accounts.

47. At the June 18 Depo, Respondent also stated that Patient A's "condition really started deteriorating" probably towards September. However, at his SI, Respondent indicated that Patient A's condition took a turn for the worse in November and that in "November/December, she really started, you know, going downhill." At the June 18 Depo, Respondent also claimed that he was not aware that Paralegal was a caregiver for Patient A on November 24, 2015. Respondent further stated that he never had a conversation with Paralegal about how she became a caregiver for Patient A. However, the records of Rae Star Health Systems contain a physician's order, dated December 3, 2015, stating, "Received a call from [Paralegal] (PCG) informing the agency about an order/instructions below." The order included medication for potassium chloride and noted that the patient had a small cut on her big toe and ordered to cleanse the affected area and apply a topical antibiotic.

[6] At the June 18 Depo, Respondent admitted that these references were to his wife's Paralegal in his medical records. He also stated that his wife's office and his own were "in the same office, same floor, and people might mingle with each other, and that "she would be in the hallway." In fact, Respondent and his wife shared a receptionist in addition to the physical space where their offices were located.

## FIRST CAUSE FOR DISCIPLINE

**(Repeated Negligent Acts)**

48. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that Respondent committed repeated negligent acts in connection with his provision of medical services to Patient A. The circumstances are as follows: Paragraphs 7 through 47, inclusive, are incorporated herein by reference as if fully set forth.

Initial Evaluation, Documentation and Evaluation of Dizziness.

49. On or about July 17, 2015 and thereafter, Respondent committed negligence when he failed to adequately perform and/or document, an evaluation and assessment of Patient A at his initial visit with her, including his failure to document a full history, complete past medical history and clinical assessment. He also negligently failed to adequately follow up with the Patient's complaints of dizziness and her history of prior strokes.

(a) Regarding Patient A's presentation at her first patient visit with Respondent, he failed to adequately document a proper narrative of the patient's initial history. Instead, only two words were listed, "Hypertension" and "dizziness." He also failed to adequately describe the patient's symptoms, e.g., the location, quality, severity, duration, timing, context, modifying factors and associated signs and symptoms. None of these details were documented. Furthermore, characteristics and precipitating factors were not documented. He also failed to perform, obtain, and/or document an adequate past medical history.

(b) In addition, his diagnoses failed to include mitral regurgitation and atrial fibrillation. Respondent further failed to render any opinion or differential diagnosis regarding the etiology of the dizziness. At his subject interview, Respondent stated that the patient "was very frail," and "had clinical signs of -- congestive heart failure" and that he was concerned about protecting the patient from a stroke or a hemorrhage in the brain (results of a CT scan of the patient's head were abnormal and showed two prior strokes). Despite his alleged concerns, Respondent never adequately performed and/or documented any re-assessment, treatment and follow-up on the patient's dizziness and prior strokes at follow-up visits.

Patient A's Prior Stroke and Atrial Fibrillation.

50. On or about July 17, 2015, and thereafter, Respondent committed negligence in connection with his care of Patient A regarding the diagnosis, treatment and/or medical addressing of her atrial fibrillation and/or risk of stroke. The patient presented to him with atrial fibrillation and a history of stroke. However, his records did not include documentation adequately addressing the patient's atrial fibrillation and history of stroke; he only documented warfarin therapy. Further, his records include incorrect documentation regarding antithrombotic treatment of atrial fibrillation. In addition, his records also failed to include an adequate discussion with the patient regarding the risks and benefits of anticoagulation for atrial fibrillation given her clinical presentation.

(a) Respondent's records fail to include a narrative regarding the history of present illness. Further, there is no documentation of a discussion regarding the risks and benefits of anticoagulation for a patient with atrial fibrillation and a history of stroke in any of Respondent's notes throughout the time he cared for Patient A. CT images of Patient A's head revealed two areas of stroke. Additionally, the patient had chronic atrial fibrillation, which made her a high risk for recurrent thromboembolic stroke. Yet, atrial fibrillation was never documented, only warfarin therapy. The Patient had chronic atrial fibrillation and a pacemaker in VVIR[7] mode (the setting for atrial fibrillation). Her CHADsVASC[8] score of 7 (prior CVA 2 points, age 2 points, female, hypertension and diabetes) was very high. Patient A also had a high risk of bleeding due to prior CVA, age, a prior GI bleed, anemia and thrombocytopenia.

(b) Although chronic warfarin therapy is listed on Respondent's initial note and is

[7] VVI(R) is ventricular demand pacing. The ventricle is paced, sensed, and the pulse generator inhibits pacing output in response to a sensed ventricular event. This mode of pacing prevents ventricular bradycardia and is primarily indicated in patients with atrial fibrillation with a slow ventricular response

[8] The CHADsVASC score is a clinical prediction tool for estimating the risk of stroke in patients with atrial fibrillation (AF), a common and serious heart arrhythmia associated with thromboembolic stroke. Such a score is used to determine whether or not treatment is required with anticoagulation therapy or antiplatelet therapy, since AF can cause stasis of blood in the upper heart chambers, leading to the formation of a mural thrombus that can dislodge into the blood flow, reach the brain, cut off supply to the brain, and cause a stroke.

listed on her medication list dated July 17, 2015, it is unlikely that Patient A was taking warfarin. On or about November 18, 2015, an INR[9] test result was 1.16 which is consistent with Patient A not taking warfarin or the appropriate dose thereof. Nonetheless, the INR results and the need for regular checks were not documented in Respondent's medical record. Further, her prior doctor, Dr. W's, did not include warfarin in his last note. Warfarin had been stopped by Dr. L. in or around October 2012 due to a recurrent gastrointestinal bleed. However, Respondent's note incorrectly listed warfarin as an ongoing medication. At his SI, Respondent alleged that he still believed that Patient A was on anticoagulant therapy with warfarin. Doctors treating patients with atrial fibrillation and antithrombotic therapy should adequately discuss with them the benefits and risks of treatment, including stroke and bleeding. Options should be discussed such as aspirin, restarting Coumadin or trying newer anti coagulation medications, including Eliquis. However, no such discussion was documented. Thus, Respondent, negligently failed to discuss and/or document the risks and benefits of anticoagulation treatment for Patient A who had atrial fibrillation and a very high risk of recurrent stroke.

Dyspnea, Hypoxia, Renal Insufficiency; and Refusal of Treatment,

51. On or about July 17, 2015 and thereafter, Respondent committed negligence in connection with his care of Patient A regarding his failure on or about December 18, 2015, to adequately perform and/or document, an adequate evaluation, assessment and treatment plan for Patient A regarding her health conditions, including, dyspnea, hypoxia, renal insufficiency, and cardiac health issues, including congestive heart failure.

52. On or about July 17, 2015, and thereafter, Respondent committed negligence in connection with his care of Patient A regarding his failure on December 18, 2015, to adequately perform and/or document, the patient's refusal of treatment, including, an informed refusal by the patient to undergo a hospital evaluation, and/or to see a nephrologist, among others.

[9] International Normalised Ratio (INR) testing is well established as an integral part of warfarin treatment. INR has a critical role in maintaining the warfarin response within a therapeutic range, to provide the benefits of anticoagulation, while avoiding the risks of hemorrhage.

53. On or about December 18, 2015, Respondent saw Patient A with a chief complaint of dyspnea and lower extremity edema. However, he failed to document any narrative regarding the history of present illness. He also failed to describe any symptoms, i.e., the location, quality, severity, duration, timing, context, modifying factors and associated signs and symptoms. His records were inadequate and inaccurate.

(a) Respondent's physical exam notations document a normal lung exam (not consistent with congestive heart failure) and 3-4 plus pedal edema. He also listed shortness of breath. Respondent further documented congestive heart failure in his assessment, but failed to document any narrative assessment or differential of a possible etiology. Respondent also failed to explain why Patient A would develop significant congestive heart failure (as well as worsening renal failure) or why she deteriorated. Respondent failed to explain if the patient's etiology was a systolic dysfunction, diastolic dysfunction or due to valvular disease. Respondent stated in his SI that Patient A had severe valvular disease that would require surgery, but Patient A had a more recent echocardiogram performed by Respondent that revealed only moderate mitral regurgitation, which was not significant and did not require surgery. Mitral regurgitation or valvular heart disease was never mentioned in Respondent's progress notes. The past medical records from Patient A's prior cardiologist, Dr. W., had only been received by Respondent on or about December 15, 2015, but there is no note that these records were reviewed in his December 15, 2015 chart note. No update of any diagnoses (e.g. severe mitral regurgitation) or medication list (e.g. patient not on warfarin) was documented by Respondent. These prior records should have been obtained and reviewed soon after Respondent initiated care for Patient A on or about July 17, 2015. Knowledge of past and current conditions is necessary to treat a new patient to ensure proper treatment, e.g., correct medications and testing.

(b) Hypoxia with oxygen saturation of 86% is noted and oxygen (2 liters) was recommended. However, there were no rales noted in his lung exam. He also failed to

order a chest X-ray, despite his diagnosis of CHF. Amlodipine[10] was stopped and HCTZ,[11] 12.5 mg a day was ordered, without any explanation. Patient A's creatinine had been elevated up to 1.7 and 2.6 with elevated potassium. However, these findings were never mentioned in his progress notes (e.g. diagnosis renal insuffiency and hyperkalemia). His record failed to address the elevated creatinine and potassium levels.[12] He also stated that despite his desire that she see a nephrologist, she refused to go; but this interaction was not documented. He also failed to adequately address the patient's digoxin level.[13] Due to significant hypoxia, Patient A should have been referred to the emergency room for evaluation, admission and treatment. However, Respondent's records do not address this. Given all her life-threatening conditions, Respondent should have discussed the risks and benefits of her options and clearly documented the process, including her refusal of treatment. However, he negligently failed to do so.

Placing Patient A in Hospice on or about December 31, 2015.

54. On or about July 17, 2015 and thereafter, Respondent committed negligence in connection with his care of Patient A regarding performing and/or documenting, the patient's decision making process regarding the patient's decision to choose hospice care at her home as opposed to hospitalization for end-of-life concerns, and/or a discussion of Patient A's options and alternatives for treatment. On or about December 23, 2015, Patient A's labs revealed significantly abnormality. Her kidney function had significantly deteriorated.

55. On or about December 31, 2015, Respondent alleged, incredulously, that an undocumented call occurred between Respondent and Patient A. According to Respondent, he had a five to ten minute telephone conversation with Patient A and he informed her that she was

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[10] A high blood pressure medication.

[11] Hydrochlorothiazide is a thiazide diuretic (water pill) that helps prevent your body from absorbing too much salt, which can cause fluid retention. HCTZ treats fluid retention (edema) in people with congestive heart failure, cirrhosis of the liver, or kidney disorders, or edema caused by taking steroids or estrogen. This medication is also used to treat high blood pressure (hypertension).

[12] Elevated creatinine and potassium levels can indicate impaired kidney function or kidney disease. Was elevated creatinine from worsening diabetic neuropathy, prerenal from dehydration from diuretics or from poor cardiac output?

[13] Digoxin medication is excreted by the kidneys and can cause side effects of nausea and anorexia (that were not noted).

getting worse and that she wanted to know her options. According to Respondent, Patient A was not interested in aggressive measures including hospitalization or dialysis. He alleged that he discussed options with Patient A, and that she opted for hospice. However, Respondent is not sure about these facts. Respondent may have had this discussion on Patient A's visit on or about December 18, 2015. In any event, Respondent failed to document any discussions with the patient regarding hospice care as an option. Respondent did sign an order, but it did not contain an adequate detailing of the process and options. He also ordered that the patient be discharged from her prior facility.

**SECOND CAUSE FOR DISCIPLINE**

**(Gross Negligence and/or Repeated Negligent Acts)**

56. Respondent is subject to disciplinary action under Code section 2234, subdivisions (b) and (c), in that he committed acts of gross negligence and/or negligence in connection with his care and treatment of Patient A. The circumstances are as follows:

57. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth.

58. In addition, Respondent failed to adequately safeguard Patient A's interests. The patient-physician relationship entails special obligations for the physician to serve the patient's interest because of the specialized knowledge that physicians possess, the confidential nature of the relationship, the vulnerability brought on by illness, and the imbalance of expertise and power between patient and physician. Physicians must avoid an appearance of impropriety and should recognize and address ethical issues.

59. On or about July 17, 2015, and thereafter, Respondent committed gross negligence in connection with the ethical issues created by the circumstances of Respondent and his spouse providing services to Patient A and the involvement of Paralegal. Respondent created potential ethical issues. Beginning in or around April 2015, and thereafter, Respondent's spouse provided legal services to Patient A addressing issues of her trust, conservatorship, and who could make medical decisions for her if she became incapacitated. In the other part of their shared office suite, Respondent took over medical care for Patient A and approximately five months later

ordered hospice as an end of life option for her.[14] Compounding this situation, Paralegal became more involved in Patient A's care over time, including in connection with her changes in home care, accompanying Patient A to medical appointments, the source of contact for hospice, the title of home caregiver, the title of "DPOA" when Patient A entered hospice care, and financial transactions on behalf of Patient A, including gifts. The situation created risks of a conflict of interests that were potentially detrimental to Patient A. Further, Respondent's documentation failed to provide sufficient support regarding his rationale for taking over Patient A's care. It is not clear why Patient A should travel over sixteen miles from her home to seek medical care with Respondent when she lived in Long Beach and had been receiving adequate treatment at a local hospital and from other physicians affiliated with that hospital where she had been receiving long-term care and had longstanding ties. Respondent alleged that Patient A's longtime cardiologist had retired, but this is not adequately documented in his chart. Furthermore, Respondent's records for Patient A listed the nearest relative as D.T, and Patient A's mailing address as Respondent's and his spouse's shared office location at 8333 Iowa Street #201, Downey, CA 90241 and her phone number was listed as Respondent's spouse's law office number as shown on the legal pleading for the conservatorship application). Moreover, Respondent's chart includes a letter dated November 16, 2015 from his wife addressed to the Administrator at Grace Home HealthCare (which provided care for Patient A for several years) in Long Beach, CA informing her to discharge Patient A immediately and that "your services on the above-named patient will no longer be needed effective today." The letter indicated that a copy of the Power of Attorney was attached, but this was not included in Respondent's chart. Thus, Respondent knew that his wife was involved in Patient A's care and was aware that Patient A had a designated power of attorney. Yet, he failed to document why Patient A was discharged from this service and failed to obtain copies of documents regarding who would make decisions for the

[14] The records indicate that Respondent's medical care for Patient A was not limited to cardiac issues. He managed her other issues including ordering and signing off on laboratory studies and urinalysis results, e.g., the urinalysis collected on or about December 8, 2015 was abnormal and the culture revealed Escherichia coli which was resistant to Bactrim and sensitive to levofloxacin, which Respondent addressed.

patient. The legal documents which Respondent's spouse prepared were relevant and significant to Respondent's care for Patient A and his failure to include copies of them in Patient A's chart represents ethical issues including whether or not his decision to place Patient A on hospice was appropriate in light of the possible conflicting incentives.[15] Paralegal's involvement in Patient A's care also created an additional conflict of interest. Paralegal was listed as the first DPOA with Sunset Hospice Care and she represented herself as the caregiver and spoke with the hospice call nurse on or about January 6, 2016. Her name appears in Respondent's chart as well as a caregiver for Patient A. Respondent created potential risks for foreseeable problems that could negatively affect Patient A by assuming the care of Patient A while she was also a client of his spouse and could be potentially affected by her and/or Paralegal. Respondent failed to adequately document an order for hospice in light of the foregoing circumstances and risks. The conservatorship records and records of other providers further document potential issues surrounding whether Patient A possessed the mental capacity to make important decisions about her care at times, including whether to be placed in hospice care. Respondent's compromised judgement in connection with his spouse's business is further evinced by the code violation when he allowed her to illicitly conduct her legal practice in a patient room in his medical practice.

60. On or about July 17, 2015, and thereafter, Respondent committed gross negligence in connection with his failure to adequately safeguard Patient A's interest in connection with his decision to admit Patient A to hospice in light of the risks to her welfare, including her advanced age, chronic conditions, and vulnerabilities (which had required assistance). This decision was against the backdrop of amendments to Patient A's trust in April 2015 that were facilitated by Respondent's wife. Patient A's advanced health care directive, dated April 21, 2015, named Patient A's grandson and his spouse as agents to make all health care decisions for Patient A. However, they were not contacted until after Patient A passed away. Instead, a court-appointed attorney who investigated the conservatorship application found that Respondent's wife stated that all of Patient A's estate planning documents were in place and that another individual, D.T., was the "Agent under her Advance Health Care Directive . . . acting as her Agent." Further,

[15] Patient A's net worth was estimated to be over one million dollars.

Respondent failed to adequately document any of Patient A's designated decision makers. This occurred in the context of Respondent's wife preparing a purported amendment to Patient A's trust and legal documentation regarding health care decision making authority.

61. On or about July 17, 2015, and thereafter, Respondent committed gross negligence in connection with his care for Patient A by failing to safeguard her interests in connection with his overall care for her in light of the risks to her health. The circumstances surrounding the involvement of his spouse and Paralegal while Respondent managed Patient A's health created risks, including that Paralegal would become more involved in Patient A's care, without appropriate authorization. Patient A developed bed sores while Paralegal (who was not a licensed healthcare provider) served as Patient A's home caregiver, which were not treated appropriately,[16] and eventually developed into painful stage III (which is defined as full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to but not through underlying fascia and presents as a deep crater). This was present on Patient A's admission to Diamond Health Care Services on or about January 17, 2016 and orders were made to clean the ulcer with saline, pat dry, apply hydrogel and cover with dry dressing daily and elevate the bilateral lower extremities on pillows while in bed / chair. Although Respondent alleges that he did not know that Paralegal was Patient A's home care provider, documents which Respondent had signed include Paralegal's name. In addition, Diamond Health Care Services' facesheet (upon transfer from Sunset Hospice) showed Paralegal's name and phone number as a caregiver. Respondent did not request that another physician take over her care when he placed Patient A on hospice with Sunset Health Care on December 31 2015, and Respondent did not transfer total responsibility to the hospice physician. The nurse accepted a verbal order from Respondent on or about December 31, 2015, where he certified that she was terminally ill with a life expectancy of six months or less. Respondent also signed the statement that updates on the Plan of Care will be forwarded to him on a regular basis and that he would be contacted directly should the need arise for a change in or addition to current care. Respondent also agreed to sign

[16] Patient A's nieces testified that Paralegal ordered the staff working with Patient A at her home to apply corn starch.

the death certificate and did not agree to have the hospice physician assume total responsibility for the care of the patient. Thus, Respondent was responsible for Patient A while she was treated under the care of Sunset Health Care.

62. The acts and/or omissions by Respondent set forth in this second cause for discipline with respect to Patient A, either collectively or in any combination thereof, constitute repeated negligent acts.

## THIRD CAUSE FOR DISCIPLINE

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

63. Respondent is subject to disciplinary action under Code section 2266 in that Respondent failed to maintain adequate and accurate records related to the provision of medical services to a patient. The circumstances are as follows:

64. The allegations of the First and Second Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

65. In addition, during his subject interview with the Board investigator, Respondent admitted that he failed to document important information, including when he discussed Patient A's office visit on or about December 1, 2015, and that he recommended that she see a nephrologist "because of the kidney deteriorating," but she refused. And, he failed to document that refusal. He also was inconsistent in his responses to discussing Patient A's refusal of hospitalization and the end-of-life options for Patient A.

66. In addition, Respondent's documentation of Patient A's clinical status is inconsistent with someone who is terminally ill.[17] Thus, his record keeping failed to adequately support his

[17] Patient A had known heart disease and MDS (a blood disorder), which were chronically stable. She had atrial fibrillation and had been taking Coumadin (a blood thinner). Her laboratory studies dated December 23, 2015, showed that her CBC was quite stable and her laboratory studies dated December 29, 2015, were marked as stable as well. Yet for some inexplicable reason, Respondent decided to place Patient A on hospice two days later. Similarly, while Patient A's renal function fluctuated, Respondent did not clearly address whether or not the patient's renal status was stable; and if he felt they were not, he failed to consult a nephrologist before committing her to hospice. Further, Patient A's cardiac status had not significantly changed while Respondent saw her from when she was seen by her prior cardiologist Dr. W. Patient A also complained of dizziness in or around July of 2015 which Respondent failed to work up. In or around November of 2015, the patient was in no acute distress. On or about December 1, 2015, Patient A denied chest pain or shortness of breath and Respondent

decisions.

## FOURTH CAUSE FOR DISCIPLINE

**(Dishonesty, Corrupt Acts and General Unprofessional Conduct)**

67. Respondent is subject to disciplinary action under Code section 2234, and subdivision (e), in that his actions and/or omissions represent dishonest, corrupt acts and/or unprofessional conduct, generally. The circumstances are as follows:

68. The allegations of the First, Second and Third Causes for Discipline are incorporated herein by reference as if fully set forth.

## 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 38056, issued to Pramod Multani, M.D.;

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

3. Ordering Pramod Multani, 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: OCT 29 2020

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

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documented that her pacemaker was functioning normally, and her chest, respiratory examination and heart were found to be normal. Finally, on or about December 18, 2015, the patient's vital signs were stable; her lungs showed good air entry bilaterally; her heart was normal; and she was in no distress. Lastly, Respondent failed to assess any shortness of breath and the examination was not consistent with a patient who had shortness of breath.