

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

In the Matter of the Accusation Against:

James Mason Heaps, M.D.

**Physician's and Surgeon's
Certificate No. G 53039**

Respondent.

Case No. 800-2021-078061

DECISION

The attached Stipulated Surrender of License and 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 14, 2023.

IT IS SO ORDERED March 7, 2023.

MEDICAL BOARD OF CALIFORNIA



**Reji Varghese, Interim Executive
Director**

1 ROB BONTA
Attorney General of California
2 ROBERT MCKIM BELL
Supervising Deputy Attorney General
3 VLADIMIR SHALKEVICH
Deputy Attorney General
4 State Bar No. 173955
300 South Spring Street, Suite 1702
5 Los Angeles, California 90013
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Attorneys for Complainant
7

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2021-078061

13 JAMES MASON HEAPS, M.D.
100 UCLA Medical Plaza, Suite 383
14 Los Angeles, CA 90024

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

15 Physician's and Surgeon's Certificate G 53039,
16 Respondent.

17
18 **IT IS HEREBY STIPULATED AND AGREED** by and between the parties to the above-
19 entitled proceedings that the following matters are true:

20 **PARTIES**

21 1. William Prasifka was the Executive Director of the Medical Board of California
22 (Board). He brought this action solely in his official capacity. Reji Varghese, Interim Executive
23 Director of the Medical Board of California (Complainant), maintains this action solely in his
24 official capacity, and is represented in this matter by Rob Bonta, Attorney General of the State of
25 California, by Vladimir Shalkevich, Deputy Attorney General.

26 2. James Mason Heaps, M.D. is represented in this proceeding by attorney Tracy Green,
27 c/o Green and Associates, 800 West Sixth Street, Suite 450, Los Angeles, California 90017.
28

1 3. On July 16, 1984, the Board issued Physician's and Surgeon's Certificate G 53039 to
2 James Mason Heaps, M.D. (Respondent). Respondent's Physician's and Surgeon's Certificate
3 expired on October 31, 2019, and has not been renewed.

4 **JURISDICTION**

5 4. Accusation No. 800-2021-078061 was filed before the Board, and is currently
6 pending against Respondent. The Accusation and all other statutorily required documents were
7 properly served on Respondent on or about July 15, 2022. Respondent timely filed his Notice of
8 Defense contesting the Accusation. A copy of Accusation No. 800-2021-078061 is attached as
9 Exhibit A and incorporated by reference.

10 **ADVISEMENT AND WAIVERS**

11 5. Respondent has carefully read, fully discussed with counsel, and understands the
12 charges and allegations in Accusation No. 800-2021-078061. Respondent also has carefully read,
13 fully discussed with counsel, and understands the effects of this Stipulated Surrender of License
14 and Order.

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

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

23 **CULPABILITY**

24 8. Respondent understands that the charges and allegations in Accusation No. 800-2021-
25 078061, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and
26 Surgeon's Certificate.

27 9. For the purpose of resolving the Accusation without the expense and uncertainty of
28 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual

1 basis for the charges in the Accusation and that those charges constitute cause for discipline.
2 Respondent hereby gives up his right to contest that cause for discipline exists based on those
3 charges.

4 10. Respondent understands that by signing this stipulation he enables the Board to issue
5 an order accepting the surrender of his Physician's and Surgeon's Certificate without further
6 process.

7 CONTINGENCY

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

17 12. The parties understand and agree that Portable Document Format (PDF) and facsimile
18 copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures
19 thereto, shall have the same force and effect as the originals.


20 13. In consideration of the foregoing admissions and stipulations, the parties agree that
21 the Board may, without further notice or formal proceeding, issue and enter the following Order:

22 ORDER

23 **IT IS HEREBY ORDERED THAT** Physician's and Surgeon's Certificate No. G 53039,
24 issued to Respondent James Mason Heaps, M.D., is surrendered and accepted by the Board.

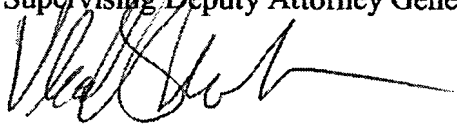
25 1. The surrender of Respondent's Physician's and Surgeon's Certificate and the
26 acceptance of the surrendered license by the Board shall constitute the imposition of discipline
27 against Respondent. This stipulation constitutes a record of the discipline and shall become a part
28 of Respondent's license history with the Board.

1 I have read and fully discussed with Respondent James Mason Heaps, M.D. the terms and
2 conditions and other matters contained in this Stipulated Surrender of License and Order. I
3 approve its form and content.

4 DATED: MARCH 3, 2023 
5 TRACY GREEN
6 Attorney for Respondent

7 **ENDORSEMENT**

8 The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted
9 for consideration by the Medical Board of California of the Department of Consumer Affairs.

10 DATED: March 3, 2023 Respectfully submitted,
11
12 ROB BONTA
13 Attorney General of California
14 ROBERT MCKIM BELL
15 Supervising Deputy Attorney General
16 
17 VLADIMIR SHALKEVICH
18 Deputy Attorney General
19 Attorneys for Complainant

20 LA2022602300

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Exhibit A

Accusation No. 800-2021-078061

1 ROB BONTA
Attorney General of California
2 ROBERT MCKIM BELL
Supervising Deputy Attorney General
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9 **BEFORE THE**
10 **MEDICAL BOARD OF CALIFORNIA**
11 **DEPARTMENT OF CONSUMER AFFAIRS**
12 **STATE OF CALIFORNIA**

13 In the Matter of the Accusation Against:

Case No. 800-2021-078061

14 JAMES MASON HEAPS, M.D.

A C C U S A T I O N

15 100 UCLA Medical Plaza, Suite 383
Los Angeles, CA 90024

16 Physician's and Surgeon's Certificate G 53039,
17 Respondent.

18
19 **PARTIES**

20 1. William Prasifka (Complainant) brings this Accusation solely in his official capacity
21 as the Executive Director of the Medical Board of California (Board).

22 2. On July 16, 1984, the Board issued Physician's and Surgeon's Certificate Number G
23 53039 to James Mason Heaps, M.D. (Respondent).

24 3. On July 30, 2019, in the Los Angeles Superior Court case entitled *People of the State*
25 *of California vs. James Heaps*, Los Angeles Superior Court case number LAXSA100560-01,
26 Respondent was ordered to cease and desist from the practice of medicine as a condition of bail
27 during the pendency of that criminal matter.
28

1 4. Respondent's Physician's and Surgeon's Certificate No. G 53039 expired on October
2 31, 2019, and has not been renewed.

3 **JURISDICTION**

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

7 6. Section 2227 of the Code states:

8 (a) A licensee whose matter has been heard by an administrative law judge of
9 the Medical Quality Hearing Panel as designated in Section 11371 of the Government
10 Code, or whose default has been entered, and who is found guilty, or who has entered
into a stipulation for disciplinary action with the board, may, in accordance with the
provisions of this chapter:

11 (1) Have his or her license revoked upon order of the board.

12 (2) Have his or her right to practice suspended for a period not to exceed one
13 year upon order of the board.

14 (3) Be placed on probation and be required to pay the costs of probation
monitoring upon order of the board.

15 (4) Be publicly reprimanded by the board. The public reprimand may include a
16 requirement that the licensee complete relevant educational courses approved by the
board.

17 (5) Have any other action taken in relation to discipline as part of an order of
18 probation, as the board or an administrative law judge may deem proper.

19 (b) Any matter heard pursuant to subdivision (a), except for warning letters,
20 medical review or advisory conferences, professional competency examinations,
21 continuing education activities, and cost reimbursement associated therewith that are
agreed to with the board and successfully completed by the licensee, or other matters
made confidential or privileged by existing law, is deemed public, and shall be made
available to the public by the board pursuant to Section 803.1.

22 7. Section 2228.1 of the Code states, in pertinent part:

23 (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the
24 board ... shall require a licensee to provide a separate disclosure that includes the licensee's
25 probation status, the length of the probation, the probation end date, all practice restrictions
26 placed on the licensee by the board, the board's telephone number, and an explanation of
27 how the patient can find further information on the licensee's probation on the licensee's
profile page on the board's online license information internet website, to a patient or the
28 patient's guardian or health care surrogate before the patient's first visit following the
probationary order while the licensee is on probation pursuant to a probationary order made
on and after July 1, 2019, in any of the following circumstances:

1 (1) A final adjudication by the board following an administrative hearing or
2 admitted findings or prima facie showing in a stipulated settlement
3 establishing any of the following:

4 (A) The commission of any act of sexual abuse, misconduct, or relations
5 with a patient or client as defined in Section 726 or 729...

6 8. Section 2234 of the Code, states:

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

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

12 (b) Gross negligence.

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

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

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

25 (d) Incompetence.

26 (e) The commission of any act involving dishonesty or corruption that is
27 substantially related to the qualifications, functions, or duties of a physician and
28 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.

9. 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.

10. Section 725 of the Code states, in pertinent part:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or
administering of drugs or treatment, repeated acts of clearly excessive use of
diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or

1 treatment facilities as determined by the standard of the community of licensees is
unprofessional conduct for a physician and surgeon...

2 (b) Any person who engages in repeated acts of clearly excessive prescribing or
3 administering of drugs or treatment is guilty of a misdemeanor and shall be punished
4 by a fine of not less than one hundred dollars (\$100) nor more than six hundred
dollars (\$600), or by imprisonment for a term of not less than 60 days nor more than
180 days, or by both that fine and imprisonment.

5 (c) A practitioner who has a medical basis for prescribing, furnishing,
6 dispensing, or administering dangerous drugs or prescription controlled substances
shall not be subject to disciplinary action or prosecution under this section.

7 (d) No physician and surgeon shall be subject to disciplinary action pursuant to
8 this section for treating intractable pain in compliance with Section 2241.5.

9 11. Section 726 of the Code states:

10 (a) The commission of any act of sexual abuse, misconduct, or relations with a
11 patient, client, or customer constitutes unprofessional conduct and grounds for
disciplinary action for any person licensed under this or under any initiative act
referred to in this division.

12 (b) This section shall not apply to consensual sexual contact between a licensee
13 and his or her spouse or person in an equivalent domestic relationship when that
licensee provides medical treatment, to his or her spouse or person in an equivalent
14 domestic relationship.

15 12. Section 729 of the Code states:

16 (a) Any physician and surgeon, psychotherapist, alcohol and drug abuse
17 counselor or any person holding himself or herself out to be a physician and surgeon,
18 psychotherapist, or alcohol and drug abuse counselor, who engages in an act of sexual
19 intercourse, sodomy, oral copulation, or sexual contact with a patient or client, or
with a former patient or client when the relationship was terminated primarily for the
purpose of engaging in those acts, unless the physician and surgeon, psychotherapist,
20 or alcohol and drug abuse counselor has referred the patient or client to an
independent and objective physician and surgeon, psychotherapist, or alcohol and
21 drug abuse counselor recommended by a third-party physician and surgeon,
psychotherapist, or alcohol and drug abuse counselor for treatment, is guilty of sexual
exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse
counselor.

22 (b) Sexual exploitation by a physician and surgeon, psychotherapist, or alcohol
23 and drug abuse counselor is a public offense:

24 (1) An act in violation of subdivision (a) shall be punishable by imprisonment
25 in a county jail for a period of not more than six months, or a fine not exceeding one
thousand dollars (\$1,000), or by both that imprisonment and fine.

26 (2) Multiple acts in violation of subdivision (a) with a single victim, when the
27 offender has no prior conviction for sexual exploitation, shall be punishable by
imprisonment in a county jail for a period of not more than six months, or a fine not
exceeding one thousand dollars (\$1,000), or by both that imprisonment and fine.

28 (3) An act or acts in violation of subdivision (a) with two or more victims shall

1 be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the
2 Penal Code for a period of 16 months, two years, or three years, and a fine not
3 exceeding ten thousand dollars (\$10,000); or the act or acts shall be punishable by
4 imprisonment in a county jail for a period of not more than one year, or a fine not
5 exceeding one thousand dollars (\$1,000), or by both that imprisonment and fine.

6 (4) Two or more acts in violation of subdivision (a) with a single victim, when
7 the offender has at least one prior conviction for sexual exploitation, shall be
8 punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal
9 Code for a period of 16 months, two years, or three years, and a fine not exceeding
10 ten thousand dollars (\$10,000); or the act or acts shall be punishable by imprisonment
11 in a county jail for a period of not more than one year, or a fine not exceeding one
12 thousand dollars (\$1,000), or by both that imprisonment and fine.

13 (5) An act or acts in violation of subdivision (a) with two or more victims, and
14 the offender has at least one prior conviction for sexual exploitation, shall be
15 punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal
16 Code for a period of 16 months, two years, or three years, and a fine not exceeding
17 ten thousand dollars (\$10,000).

18 For purposes of subdivision (a), in no instance shall consent of the patient or
19 client be a defense. However, physicians and surgeons shall not be guilty of sexual
20 exploitation for touching any intimate part of a patient or client unless the touching is
21 outside the scope of medical examination and treatment, or the touching is done for
22 sexual gratification.

23 (c) For purposes of this section:

24 (1) "Psychotherapist" has the same meaning as defined in Section 728.

25 (2) "Alcohol and drug abuse counselor" means an individual who holds himself
26 or herself out to be an alcohol or drug abuse professional or paraprofessional.

27 (3) "Sexual contact" means sexual intercourse or the touching of an intimate
28 part of a patient for the purpose of sexual arousal, gratification, or abuse.

(4) "Intimate part" and "touching" have the same meanings as defined in
Section 243.4 of the Penal Code.

(d) In the investigation and prosecution of a violation of this section, no person
shall seek to obtain disclosure of any confidential files of other patients, clients, or
former patients or clients of the physician and surgeon, psychotherapist, or alcohol
and drug abuse counselor.

(e) This section does not apply to sexual contact between a physician and
surgeon and his or her spouse or person in an equivalent domestic relationship when
that physician and surgeon provides medical treatment, other than psychotherapeutic
treatment, to his or her spouse or person in an equivalent domestic relationship.

(f) If a physician and surgeon, psychotherapist, or alcohol and drug abuse
counselor in a professional partnership or similar group has sexual contact with a
patient in violation of this section, another physician and surgeon, psychotherapist, or
alcohol and drug abuse counselor in the partnership or group shall not be subject to
action under this section solely because of the occurrence of that sexual contact.

1 COST RECOVERY

2 13. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
3 administrative law judge to direct a licensee found to have committed a violation or violations of
4 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
5 enforcement of the case, with failure of the licensee to comply subjecting the license to not being
6 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be
7 included in a stipulated settlement.

8 FACTUAL ALLEGATIONS

9 Patient 1¹

10 14. Patient 1 was a 47-year-old female with a history of breast cancer dating back to
11 2005, when she was referred to Respondent by her primary care physician for evaluation of
12 “[d]ysfunctional uterine bleeding, perhaps atrophic.”

13 15. Patient 1’s first visit with Respondent occurred on August 11, 2006. At that first
14 visit, Respondent asked Patient 1 if he could see the surgical reconstruction from her breast
15 cancer surgery as she had TRAM flaps for her reconstructive operations. Respondent stood in
16 front of Patient 1 and took 3 steps forward and as her gown was open, he grabbed both breasts
17 and squeezed them with both hands at the same time. He then told her that they looked nice.
18 Respondent did not document a breast examination. He then had her get in position for a pelvic
19 exam and commented on her toenail color, telling her that it was “sexy” and ran his fingers up her
20 inner leg and inner thigh and her perineum and then placed the speculum into her vagina. After he
21 took a Pap smear and performed a pelvic exam, Respondent stood up next to her and placed his
22 hand on her lower abdomen above her pubic bone and moved his hand in a shaking motion that
23 was stimulating. All the while that he was making these shaking motions, Respondent engaged in
24 small talk with Patient 1 about mundane topics. Patient 1 reports that no chaperone was present
25 for this examination, nor was there a chaperone present for any pelvic examination for the first
26 five or six years of the time that she was under Respondent’s care. At that same first visit, Patient

27 ¹ Numbers instead of names are used to protect patients’ privacy. The names of the
28 patients are known to the Respondent or will be made available to him in response to a Request
for Discovery.

1 1 underwent the first of many transvaginal ultrasounds performed by Respondent. The
2 transvaginal ultrasound was always performed by Respondent without a chaperone in a back
3 room in the office. Patient 1 describes the examinations as consisting of multiple entrances and
4 exits with the vaginal probe, lasting for approximately 30 minutes each time they occurred.
5 Patient 1 described the probing with the repeated in and out motion as "harsh." At the conclusion
6 of this first visit, Respondent told Patient 1 that she needed to come back for serial visits every 3
7 months for transvaginal ultrasounds as she was at an increased risk for ovarian cancer.
8 Respondent did not consider and did not document considering genetic testing to establish
9 whether or not Patient 1 was actually at an increased risk of ovarian cancer. No breast exam was
10 documented. Respondent told Patient 1 that he could detect ovarian cancer early, by performing
11 transvaginal ultrasounds.

12 16. Patient 1 continued to see Respondent for repeated follow up pelvic examinations and
13 transvaginal ultrasounds through April 14, 2016. For the first 2 years she had pelvic exams and
14 transvaginal ultrasounds every four to six months and then spread the visits out to annually, for
15 approximately four years. Patient 1 believed Respondent when he told her that she had an
16 increased risk of ovarian cancer and he could catch ovarian cancer early with these procedures.

17 17. Respondent told Patient 1 that she had multiple cysts on her ovaries that could
18 become cancer. She describes that over the years of examinations, Respondent's touching of her
19 became progressively more intimate and she was concerned that during every examination he
20 performed, he was touching her "in places that normal physicians would not really touch."
21 Respondent would continue to make small talk about non-medical things such as her residence in
22 Hawaii while massaging her lower abdomen above the pubic bone and moving his hand in a
23 shaking motion while she was in lithotomy.

24 18. Respondent rarely had a chaperone in the room for her pelvic examinations and
25 usually the assistant came in to collect the Pap smear and then left. There was never a chaperone
26 in the room for the transvaginal ultrasounds. Because of prior history of breast cancer, Patient 1
27 was routinely followed by the UCLA Breast Center, but Respondent routinely performed breast
28 exams on Patient 1, many of which were not documented.

1 19. When Respondent saw Patient 1 on December 2, 2014, Respondent noted:
2 "IC [intercourse] rare secondary to husband issues." During that visit, Respondent performed a
3 rectal examination, and did not document it. He told Patient 1 to return in one year for a re-
4 examination.

5 20. Patient 1's final visit with Respondent took place on April 14, 2016. At this visit
6 Respondent commented again on her toenail color and ran his fingers up her leg to her inner thigh
7 and her perineum as he always did. A chaperone was in the room, standing directly behind
8 Respondent. Respondent's body blocked the chaperone's ability to visualize Respondent's hand
9 movements. Once the Pap smear was collected, the chaperone left. At this point, Respondent
10 performed a rectal exam, surprising Patient 1, because Respondent did not ask her permission to
11 do so. Respondent did not document performing this rectal exam. Respondent then told Patient
12 1: "Oh, I forgot, one more thing" and he touched and stimulated Patient 1's clitoris. She does not
13 recall him changing gloves after the rectal examination. At this juncture the chaperone re-entered
14 the room, which startled Respondent. Respondent stood up, took off his gloves, and said: "I'm
15 done." Thereafter, Respondent left the examination room without speaking further with Patient 1.
16 Patient 1 never returned to see Respondent after this visit and requested her primary care doctor
17 to refer her to a new gynecologist.

18 **Patient 2**

19 21. Patient 2 was a 42-year-old female when she presented to Respondent for advice on
20 her recommended gynecologic care on or about January 16, 2015. She self-referred and related in
21 her intake that her mother had ovarian cancer and that her husband had a vasectomy. During that
22 visit Respondent performed a complete examination including a breast and pelvic exam and a
23 transvaginal ultrasound on Patient 2.

24 22. Respondent documented that the indication for the ultrasound was an ovarian cancer
25 screening, and that he discussed the "pros/cons" of screening and failures. He also documented
26 that he reviewed the statistics on ovarian cancer and inheritance. There is no discussion of genetic
27 testing in either Patient 2 or her mother. Respondent recommended that Patient 2 continue in
28 follow-up with him every 4-6 months for transvaginal ultrasounds for ovarian cancer screening.

1 Respondent explained to Patient 2 that these ultrasounds should continue every 4 months through
2 age 50, and then occur every 3 months. He told her that he had enough experience to be able to
3 catch ovarian cancer with these exams and ultrasounds. Patient 2 asked Respondent for CA 125
4 measurements, but he told her that they were not accurate. Respondent never obtained a CA 125
5 measurement for Patient 2, nor any other screening other than transvaginal ultrasounds.

6 23. Patient 2 returned to see Respondent approximately every 4 months for a pelvic exam
7 and transvaginal ultrasound for eleven (11) documented visits in total, and through March 23,
8 2018. During the performance of the transvaginal ultrasounds, Respondent never asked
9 permission to insert the probe or ever gave Patient 2 any warning of the impending insertion.
10 Respondent never recommended that Patient 2 have genetic testing to evaluate her risk for
11 ovarian cancer, and never established and/or documented establishing that Patient 2 was at an
12 increased risk of ovarian cancer. Respondent did discuss prophylactic surgery with Patient 2, on
13 one occasion, however, he then told her that she was not a candidate for this surgery as she had
14 Factor V Leiden deficiency and therefore could go on hormone replacement therapy.

15 24. At one of Patient 2's visits with Respondent, approximately in March, 2017,
16 Respondent grabbed both of Patient 2's breasts with his two hands while she was lying in a supine
17 position. He did not ask permission to examine her breasts. There was no chaperone in the room.
18 Patient 2 described that this was unlike any prior breast exam, and it felt as though Respondent
19 was massaging her breasts and was more sensual than medical. At that time, Respondent brought
20 his face into close proximity to Patient 2's face, and she thought he would kiss her. Respondent
21 made eye contact with Patient 2 and asked her if she was happy in her marriage. Patient 2 stated:
22 "that time scared me. And I called my husband, I called my cousin. But I was really mad at
23 myself for being scared because I thought he was this great, nice guy and why would I be scared
24 of him." She remained in Respondent's care until March 23, 2018. After March 23, 2018, she
25 called to make an appointment with Respondent, but was told that he was retiring.

26 ///

27 ///

28 ///

1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Sexual Misconduct)**

3 25. Respondent James Mason Heaps, M.D. is subject to disciplinary action under section
4 726 of the Code in that he engaged in sexual misconduct with two patients. The circumstances
5 are as follows:

6 26. The allegations of paragraphs 13 through 24 are incorporated herein by reference.

7 **SECOND CAUSE FOR DISCIPLINE**

8 **(Sexual Exploitation)**

9 27. Respondent James Mason Heaps, M.D. is subject to disciplinary action under section
10 729 of the Code in that he engaged in sexual exploitation by touching intimate parts of two
11 patients' bodies for the purpose of sexual arousal, gratification or abuse. The circumstances are
12 as follows:

13 28. The allegations of paragraphs 13 through 24 are incorporated herein by reference.

14 **THIRD CAUSE FOR DISCIPLINE**

15 **(Gross Negligence)**

16 29. Respondent James Mason Heaps, M.D. is subject to disciplinary action under section
17 2234, subdivision (b) of the Code in that he was grossly negligent in the care and treatment of two
18 patients. The circumstances are as follows:

19 30. The allegations of paragraphs 13 through 24 are incorporated herein by reference.

20 31. Each of the following constitutes a separate instance of gross negligence:

21 A) Sexual misconduct with Patient 1 as alleged herein was an extreme departure
22 from the standard of care.

23 B) Respondent's failure to perform and/or document genetic cancer screening and
24 a thorough family history or pedigree analysis to establish that Patient 1 had an increased risk of
25 ovarian cancer was an extreme departure from the standard of care.

26 C) Respondent's recommendation of and performance of transvaginal ultrasounds
27 on Patient 1 every three to six months without establishing an increased risk for developing
28 ovarian cancer was an extreme departure from the standard of care.

1 D) Performing examinations of Patient 1's breasts, suprapubic area, rectum and
2 genitalia, in the manner alleged herein was an extreme departure from the standard of care.

3 E) If Respondent believed that Patient 1 had an increased risk of developing
4 ovarian cancer, his failure to counsel and/or document counseling her for prophylactic surgical
5 treatment, to decrease that risk, was an extreme departure from the standard of care.

6 F) Sexual misconduct with Patient 2 as alleged herein was an extreme departure
7 from the standard of care.

8 G) Performing examinations of Patient 2's breasts, and genitalia, in the manner
9 alleged herein was an extreme departure from the standard of care.

10 H) Respondent's failure to perform and/or document genetic cancer screening and
11 a thorough family history or pedigree analysis to establish that Patient 2 had an increased risk of
12 ovarian cancer was an extreme departure from the standard of care.

13 I) Respondent's performance of transvaginal ultrasounds on Patient 2 every four
14 months without establishing an increased risk for developing ovarian cancer was an extreme
15 departure from the standard of care.

16 J) If Respondent believed that Patient 2 had an increased risk of developing
17 ovarian cancer, his failure to counsel and/or document counseling her for prophylactic surgical
18 treatment to decrease that risk was an extreme departure from the standard of care.

19 **FOURTH CAUSE FOR DISCIPLINE**

20 **(Repeated Negligent Acts)**

21 32. Respondent James Mason Heaps, M.D. is subject to disciplinary action under section
22 2234, subdivision (c) of the Code, in that he committed repeated negligent acts in his care and
23 treatment of two patients. The circumstances are as follows:

24 33. The allegations of paragraphs 13 through 24 are incorporated herein by reference.

25 34. Each of the following constitutes a separate instance of negligence:

26 A) Sexual misconduct with Patient 1 as alleged herein was a departure from the
27 standard of care.

1 B) Respondent's failure to perform and/or document genetic cancer screening and
2 a thorough family history or pedigree analysis to establish that Patient 1 had an increased risk of
3 ovarian cancer was a departure from the standard of care.

4 C) Respondent's performance of transvaginal ultrasounds on Patient 1 every three
5 to six months without establishing an increased risk for developing ovarian cancer was a
6 departure from the standard of care.

7 D) Performing examinations of Patient 1's breasts, suprapubic area, rectum and
8 genitalia, in the manner alleged herein was a departure from the standard of care.

9 E) If Respondent believed that Patient 1 had an increased risk of developing
10 ovarian cancer, his failure to counsel and/or document counseling her for prophylactic surgical
11 treatment to decrease that risk was a departure from the standard of care.

12 F) Sexual misconduct with Patient 2 as alleged herein was a departure from the
13 standard of care.

14 G) Performing examinations of Patient 2's breasts, and genitalia, in the manner
15 alleged herein was a departure from the standard of care.

16 H) Respondent's failure to perform and/or document genetic cancer screening and
17 a thorough family history or pedigree analysis to establish that Patient 2 had an increased risk of
18 ovarian cancer was a departure from the standard of care.

19 I) Respondent's performance of transvaginal ultrasounds on Patient 2 every four
20 months without establishing an increased risk for developing ovarian cancer was a departure from
21 the standard of care.

22 J) If Respondent believed that Patient 2 had an increased risk of developing
23 ovarian cancer, his failure to counsel and/or document counseling her for prophylactic surgical
24 treatment decrease that risk was a departure from the standard of care.

25 **FIFTH CAUSE FOR DISCIPLINE**

26 **(Excessive Utilization of Diagnostic or Treatment Procedures and/or Facilities)**

27 35. Respondent James Mason Heaps, M.D. is subject to disciplinary action under section
28 725 of the Code in that he engaged in repeated acts of clearly excessive use of diagnostic

1 procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities in his
2 care and treatment of two patients. The circumstances are as follows:

3 36. The allegations of paragraphs 13 through 24 are incorporated herein by reference.

4 37. Performance of transvaginal ultrasound examinations of Patient 1 in the manner
5 alleged herein was clearly excessive and outside the standard of the community.

6 38. Performance of transvaginal ultrasound examinations of Patient 2 in the manner
7 alleged herein was clearly excessive and outside the standard of the community.

8 **SIXTH CAUSE FOR DISCIPLINE**

9 **(Failure to Maintain Adequate and Accurate Records)**

10 39. Respondent James Mason Heaps, M.D. is subject to disciplinary action under section
11 2266 of the Code in that he failed to maintain complete and accurate medical records in the care
12 and treatment of two patients. The circumstances are as follows:

13 40. The allegations of paragraphs 13 through 24 are incorporated herein by reference.

14 **PRAYER**

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

17 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 53039,
18 issued to Respondent, James Mason Heaps, M.D.;

19 2. Revoking, suspending or denying approval of Respondent's authority to supervise
20 physician assistants and advanced practice nurses;

21 3. Ordering Respondent to pay the Board the costs of the investigation and enforcement
22 of this case, and if placed on probation, the costs of probation monitoring;

23 4. If placed on probation, ordering Respondent to provide patient notification in
24 accordance with Business and Professions Code section 2228.1; and

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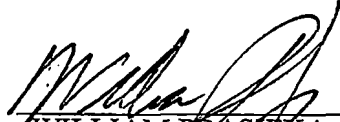
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5. Taking such other and further action as deemed necessary and proper.

DATED: JUL 15 2022



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

Complainant

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