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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>James Mason Heaps, M.D.<br><br>Physician's and Surgeon's Certificate No. G 53039<br><br>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

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
Deputy Attorney General
State Bar No. 173955
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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 Accusation Against:<br><br>JAMES MASON HEAPS, M.D.<br>100 UCLA Medical Plaza, Suite 383<br>Los Angeles, CA 90024<br><br>Physician's and Surgeon's Certificate G 53039,<br><br>Respondent. | Case No. 800-2021-078061<br><br>**STIPULATED SURRENDER OF LICENSE AND 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 was the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity. Reji Varghese, Interim Executive Director of the Medical Board of California (Complainant), maintains this action solely in his official capacity, and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Vladimir Shalkevich, Deputy Attorney General.

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

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

## JURISDICTION

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

## ADVISEMENT AND WAIVERS

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

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the 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.

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

## CULPABILITY

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

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

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

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

## CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, 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 Surrender 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.

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

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

## ORDER

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

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

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2021-078061 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $17,302 prior to issuance of a new or reinstated license.

6. 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 agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2021-078061 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 licensure.

**ACCEPTANCE**

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Tracy Green, Attorney at Law. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: March 3, 2023

JAMES MASON HEAPS, M.D.
*Respondent*

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

DATED: MARCH 3, 2023

TRACY GREEN
*Attorney for Respondent*

**ENDORSEMENT**

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

DATED: March 3, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

VLADIMIR SHALKEVICH
Deputy Attorney General
*Attorneys for Complainant*

LA2022602300

# Exhibit A

**Accusation No. 800-2021-078061**

ROB BONTA
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ROBERT MCKIM BELL
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| In the Matter of the Accusation Against: | Case No. 800-2021-078061 |
|---|---|
| JAMES MASON HEAPS, M.D.<br><br>100 UCLA Medical Plaza, Suite 383<br>Los Angeles, CA 90024<br><br>Physician's and Surgeon's Certificate G 53039,<br><br>Respondent. | **A C C U S A T I O N** |

## PARTIES

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

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

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

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

## JURISDICTION

5. 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.

6. Section 2227 of the Code states:

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

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

> (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board ... shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of 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 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) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

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

8. 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.

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

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

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished 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.

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

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

11. Section 726 of the Code states:

(a) The commission of any act of sexual abuse, misconduct, or relations with a 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.

(b) This section shall not apply to consensual sexual contact between a licensee 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 domestic relationship.

12. Section 729 of the Code states:

(a) Any physician and surgeon, psychotherapist, alcohol and drug abuse counselor or any person holding himself or herself out to be a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor, who engages in an act of sexual 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, or alcohol and drug abuse counselor has referred the patient or client to an independent and objective physician and surgeon, psychotherapist, or alcohol and 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.

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

(1) An act in violation of subdivision (a) 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.

(2) Multiple acts in violation of subdivision (a) with a single victim, when the 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.

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

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

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

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

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

(c) For purposes of this section:

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

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

(3) "Sexual contact" means sexual intercourse or the touching of an intimate 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.

## COST RECOVERY

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

## FACTUAL ALLEGATIONS

**Patient 1**[1]

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

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

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

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

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

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

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

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

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

**Patient 2**

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

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

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

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

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

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## FIRST CAUSE FOR DISCIPLINE

**(Sexual Misconduct)**

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

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

## SECOND CAUSE FOR DISCIPLINE

**(Sexual Exploitation)**

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

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

## THIRD CAUSE FOR DISCIPLINE

**(Gross Negligence)**

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

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

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

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

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

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

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

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

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

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

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

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

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

## FOURTH CAUSE FOR DISCIPLINE

**(Repeated Negligent Acts)**

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

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

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

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

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

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

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

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

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

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

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

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

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

## FIFTH CAUSE FOR DISCIPLINE

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

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

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

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

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

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

## SIXTH CAUSE FOR DISCIPLINE

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

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

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

## 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 G 53039, issued to Respondent, James Mason Heaps, M.D.;

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

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

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

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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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