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

In the Matter of the Petition to Revoke Probation Against: **THOMAS JOSEPH KASCHAK, M.D.** **PO Box 5141** **Stateline, NV 89449-5141** **Physician's and Surgeon's Certificate No. G 67586** Respondent	Case No. 800-2019-056004 **DEFAULT DECISION AND ORDER** [Gov. Code §11520]

1. On August 13, 2019, an employee of the Medical Board of California (Board), served by certified mail a copy of Petition to Revoke Probation No. 800-2019-056004, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to the address of record of Thomas Joseph Kaschak, M.D. (Respondent), which was and is PO Box 5141, Stateline, NV 89449-5141. The aforementioned documents were returned by the U.S. Postal Service marked "Not Claimed. Return to Sender." (Exhibit Package,

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Exhibit 1[1]: Petition to Revoke Probation, related documents, Declaration of Service, and envelope returned to the Board.)

2. Respondent did not file a Notice of Defense. On August 13, 2019, the Attorney General's Office served by certified mail a Courtesy Notice of Default on Respondent at his address of record. The Courtesy Notice of Default advised Respondent of the Accusation, and provided Respondent with an opportunity to request relief from default. On September 30, 2019, the aforementioned documents were returned by the U.S. Postal Service marked "Return to Sender. Unclaimed. Unable to Forward." (Exhibit Package, Exhibit 2: Courtesy Notice of Default, proof of service, and copy of returned envelope.)

FINDINGS OF FACT

I

Complainant Christine J. Lally is the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs. The charges and allegations in Accusation No. 800-2018-049166 were at all times brought and made solely in the official capacity of the Board's Interim Executive Director.

II.

On November 27, 1989, the Board issued Physician's and Surgeon's Certificate No. G 67586 to Respondent. The Physician's and Surgeon's Certificate expired on November 30, 2017, and has not been renewed. (Exhibit Package, Exhibit 3: Certificate of License.)

III

Business and Professions Code section 118 states, in pertinent part:

> (b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the license on any such ground.

[1] The evidence in support of this Default Decision and Order is contained in the "Exhibit Package."

IV

On August 13, 2019, Respondent was served with a Petition to Revoke Probation, alleging causes for revocation of his probation. The Petition and accompanying documents were duly served on Respondent. A Courtesy Notice of Default was thereafter served on Respondent.

V.

Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

Respondent failed to file a Notice of Defense within 15 days after service upon him of the Petition to Revoke Probation, and therefore waived his right to a hearing on the merits of Petition to Revoke Probation No. 800-2019-056004.

VI

The allegations of the Petition are true as follows:

In a disciplinary action entitled "In the Matter of First Amended Accusation Against Thomas Joseph Kaschak, M.D.," Case No. 02-2007-188357, the Board filed a First Amended Accusation against Respondent, charging him with unprofessional conduct. Respondent contested the charges during a six-day hearing (August 18, 2015, January 4, 2016-January 7, 2016, July 26, 2016). In her proposed decision, the administrative law judge concluded that Respondent was both grossly negligent and repeatedly negligent in his care and treatment of his patient following surgery. The Board adopted the proposed decision as its Decision and Order, effective March 3, 2017. The Decision and Order revoked Respondent's Physician's and Surgeon's Certificate. However, the revocation was stayed and Respondent's Physician's and Surgeon's Certificate was placed on probation for a period of three years with certain terms and conditions. (The Decision and Order is contained in the Exhibit Package, Exhibit A to Exhibit 1.)

On February 10, 2017, Probation Inspector Maggie Lee mailed an initial contact letter to Respondent at his address of record. Probation Inspector Lee reminded Respondent to notify the

Board immediately and in writing of any changes to his name, residence, or business address and telephone number. (Exhibit Package, Exhibit 4: Declaration of Probation Inspector Maggie Lee.)

Since Respondent's term of probation began on March 3, 2017, he has maintained his address of record and the location of his practice in Nevada, and he has not practiced medicine in California. (*Ibid.*)

Respondent has not submitted any Quarterly Declarations as required by the terms of his probation. On October 6, 2017, the Board issued a Citation and Order, in case number 800-2017-037261, to Respondent for violating his probation by failing to submit his required Quarterly Declaration. Respondent has not complied with or responded to the Citation and Order, which requires his submission of any overdue Quarterly Declarations. (Exhibit Package, Exhibit 5: Citation and Order issued October 6, 2017.)

On November 30, 2017, Respondent's Physician's and Surgeon's Certificate expired. (Exhibit Package, Exhibit 3.)

On January 29, 2018, the Board issued a Citation and Order, in case number 800-2018-040334, to Respondent for violating his probation by failing to maintain a current and renewed Physician's and Surgeon's Certificate and for failing to inform the Board of a change of address. (Exhibit Package, Exhibit 6: Citation and Order issued January 29, 2018.) Respondent has not complied with or responded to the Citation and Order, which requires his payment of a fine and orders him to provide a current address to the Board and to renew his Physician's and Surgeon's Certificate.

On various dates, including on September 12, 2018, Probation Inspector Lee mailed a letter to Respondent at his address of record, advising Respondent that, as of March 3, 2019, his period of non-practice will have exceeded two years, in violation of the terms of his probation. (Exhibit Package, Exhibit 4: Declaration of Probation Inspector Maggie Lee.)

On March 4, 2019, Probation Inspector Lee mailed a letter to Respondent at his address of record, notifying him that he had violated his probation by having remained in non-practice since the start of his probation, on March 3, 2017, in excess of the two-year maximum non-practice period allowed by the terms of his probation. The letter advised that the Board was referring the

matter for disciplinary action. (Exhibit Package, Exhibit 4: Declaration of Probation Inspector Maggie Lee.)

At all times after the effective date of Respondent's probation, Condition 9 of his probation stated as follows:

> **Non-practice While on Probation:** Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. 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 a clinical training 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 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; and General Probation Requirements.

At all times after the effective date of Respondent's probation, Condition 11 of his probation stated as follows:

> **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.

Since the start of his probation, Respondent has maintained his address of record and the location of his practice outside of California, in Nevada, and he has not practiced medicine in California. Accordingly, he has been in non-practice since March 3, 2017. Condition 9 limits the

period of Respondent's non-practice to two years. Because Respondent has remained in non-practice for a period exceeding two years, Respondent has failed to comply with Condition 9.

At all times after the effective date of Respondent's probation, Condition 6 stated:

> **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.

At all times after the effective date of Respondent's probation, Condition 7 stated:

> **General Probation Requirements:** Compliance with Probation Unit
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> Respondent shall comply with the Board's probation unit and ail terms and conditions of this Decision.
>
> Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).
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> . . . .
>
> License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.
>
> . . . .

Respondent has failed to submit any Quarterly Declarations, in violation of Condition 6 of his probation.

Also, since the start of his probation, Respondent has failed to keep the Board informed of his business and residence addresses. Further, Respondent has used a post office box as his address of record with the Board. Respondent's failure to inform the Board of his business and residence addresses and his use of a post office box as his address of record constitute violations of Condition 7 of his probation.

In addition, by allowing his Physician's and Surgeon's Certificate to expire on November 30, 2017, Respondent failed to maintain a current and renewed certificate, in violation of Condition 7 of his probation.

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V.

California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on Respondent's express admissions by way of default and the evidence before it, contained in Exhibits 1-6, finds that the allegations in Petition to Revoke Probation No. 800-2019-056004 are true.

DETERMINATION OF ISSUES

Respondent's conduct constitutes a violation of the Decision and Order in Case No. 02-2007-188357, specifically Probation Conditions 9 (Non-Practice While on Probation), and Probation Conditions 6 and 7 (Failure to Submit Quarterly Declarations, to Maintain License, and to Inform Board of Address Changes), and is cause to revoke his probation.

ORDER

IT IS SO ORDERED that Physician's and Surgeon's Certificate No. G 67586, heretofore issued to Respondent Thomas Joseph Kaschak, M.D., is revoked.

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Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on January 10, 2020.

It is so ORDERED December 11, 2019

FOR THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
Christine J. Lally
Interim Executive Director

SF2019201091
21663289

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO August 13 2019
BY: ANALYST

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

In the Matter of the Petition to Revoke Probation Against: **THOMAS JOSEPH KASCHAK, M.D.** **PO Box 5141** **Stateline, NV 89449-5141** **Physician's and Surgeon's Certificate No. G 67586** Respondent.	Case No. 800-2019-056004 PETITION TO REVOKE PROBATION

Complainant alleges:

PARTIES

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

2. On or about November 27, 1989, the Medical Board of California issued Physician's and Surgeon's Certificate Number G 67586 to Thomas Joseph Kaschak, M.D. (Respondent). The Physician's and Surgeon's Certificate expired on November 30, 2017, and has not been renewed.

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JURISDICTION

3. This Petition to Revoke Probation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code provides that the Board shall have the responsibility for the enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

5. 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.

6. Section 2228 of the Code states:

> The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:
>
> (a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.
>
> (b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.
>
> (c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.
>
> (d) Providing the option of alternative community service in cases other than violations relating to quality of care.

FACTUAL ALLEGATIONS

7. In a disciplinary action entitled "In the Matter of First Amended Accusation Against Thomas Joseph Kaschak, M.D.," Case No. 02-2007-188357, the Board filed a First Amended Accusation against Respondent, charging him with unprofessional conduct. Respondent contested the charges during a six-day hearing (August 18, 2015, January 4, 2016-January 7, 2016, July 26, 2016). In her proposed decision, the administrative law judge concluded that Respondent was

both grossly negligent and repeatedly negligent in his care and treatment of his patient following surgery. The Board adopted the proposed decision as its Decision and Order, effective March 3, 2017. The Decision and Order revoked Respondent's Physician's and Surgeon's Certificate. However, the revocation was stayed and Respondent's Physician's and Surgeon's Certificate was placed on probation for a period of three years with certain terms and conditions. A copy of the Decision and Order is attached as **Exhibit A** and is incorporated by reference.

8. Since Respondent's term of probation began on March 3, 2017, he has maintained his address of record and the location of his practice in Nevada, and he has not practiced medicine in California.

9. Since Respondent's term of probation began, he has not responded to correspondence mailed by his assigned probation inspector to his address of record with the Board or otherwise communicated with his assigned probation inspector. All of the correspondence mailed by Respondent's assigned probation inspector to him was returned as "undeliverable." The probation inspector attempted to locate a current address for Respondent by reviewing several databases of civil records, none of which indicated an alternative address for Respondent.

10. Respondent has not submitted any Quarterly Declarations as required by the terms of his probation. On October 6, 2017, the Board issued a Citation and Order, in case number 800-2017-037261, to Respondent for violating his probation by failing to submit his required Quarterly Declaration. Respondent has not complied with or responded to the Citation and Order, which requires his submission of any overdue Quarterly Declarations.

11. On November 30, 2017, Respondent's Physician's and Surgeon's Certificate expired.

12. On January 29, 2018, the Board issued a Citation and Order, in case number 800-2018-040334, to Respondent for violating his probation by failing to maintain a current and renewed Physician's and Surgeon's Certificate and for failing to inform the Board of a change of address. Respondent has not complied with or responded to the Citation and Order, which requires his payment of a fine and orders him to provide a current address to the Board and to renew his Physician's and Surgeon's Certificate.

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13. On various dates, including on September 12, 2018, Respondent's assigned probation inspector mailed a letter to Respondent at his address of record, advising Respondent that, as of March 3, 2019, his period of non-practice will have exceeded two years, in violation of the terms of his probation.

14. On March 4, 2019, Respondent's assigned probation inspector mailed a letter to Respondent at his address of record, notifying him that he had violated his probation by having remained in non-practice since the start of his probation, on March 3, 2017, in excess of the two-year maximum non-practice period allowed by the terms of his probation. The letter advised that the Board was referring the matter for disciplinary action.

FIRST CAUSE TO REVOKE PROBATION

(Violation of Probation Condition 9: Non-Practice While on Probation)

15. At all times after the effective date of Respondent's probation, Condition 9 of his probation stated as follows:

> **Non-practice While on Probation:** Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. 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 a clinical training 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 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; and General Probation Requirements.

16. At all times after the effective date of Respondent's probation, Condition 11 of his probation stated as follows:

> **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.

17. Since the start of his probation, Respondent has maintained his address of record and the location of his practice outside of California, in Nevada, and he has not practiced medicine in California. Accordingly, he has been in non-practice since March 3, 2017. Condition 9 limits the period of Respondent's non-practice to two years. Because Respondent has remained in non-practice for a period exceeding two years, Respondent has failed to comply with Condition 9.

18. Respondent's violation of Condition 9 of his probation constitutes cause to revoke his probation, pursuant to Condition 11 of his probation.

SECOND CAUSE TO REVOKE PROBATION

(Violations of Probation Conditions 6 and 7: Failure to Submit Quarterly Declarations, to Maintain License, and to Inform Board of Address Change)

19. At all times after the effective date of Respondent's probation, Condition 6 stated:

> **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.

20. At all times after the effective date of Respondent's probation, Condition 7 stated:

> **General Probation Requirements:** Compliance with Probation Unit
>
> Respondent shall comply with the Board's probation unit and ail terms and conditions of this Decision.
>
> Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

. . . .

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

. . . .

21. Respondent has failed to submit any Quarterly Declarations, in violation of Condition 6 of his probation.

22. Also, since the start of his probation, Respondent has failed to keep the Board informed of his business and residence addresses. Further, Respondent has used a post office box as his address of record with the Board. Respondent's failure to inform the Board of his business and residence addresses and his use of a post office box as his address of record constitute violations of Condition 7 of his probation.

23. In addition, by allowing his Physician's and Surgeon's Certificate to expire on November 30, 2017, Respondent failed to maintain a current and renewed certificate, in violation of Condition 7 of his probation.

24. Respondent's violations of Conditions 6 and 7 of his probation constitute cause to revoke his probation, pursuant to Condition 11 of his probation.

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 the probation that was granted by the Medical Board of California in Case No. 02-2007-188357 and imposing the disciplinary order that was stayed thereby revoking Physician's and Surgeon's Certificate No. G 67586 issued to Thomas Joseph Kaschak, M.D.;

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

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3. Ordering Thomas Joseph Kaschak, M.D., if placed on probation, to pay the costs of probation monitoring; and

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

DATED: August 13, 2019

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

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Exhibit A

Decision and Order

Medical Board of California Case No. 02-2007-188357

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

In the Matter of the First Amended Accusation Against:	)	
THOMAS JOSEPH KASCHAK, M.D.	)	Case No. 02-2007-188357
Physician's and Surgeon's Certificate No. G 67586	)	OAH No. 2014100546
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on March 3, 2017.

IT IS SO ORDERED: February 2, 2017.

MEDICAL BOARD OF CALIFORNIA

Jamie Wright, JD, Chair
Panel A

MEDICAL BOARD OF CALIFORNIA
I do hereby certify that this document is a true and correct copy of the original on file in this office.
S. Woods
Signature
For Custodian of Records
Title
5/17/2019
Date

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

In the Matter of the First Amended Accusation Against: THOMAS JOSEPH KASCHAK, M.D. Physician's and Surgeon's Certificate Number G 67586 Respondent.	Case No. 02-2007-188357 OAH No. 2014100546

PROPOSED DECISION

A hearing convened in this matter before Administrative Law Judge Marilyn A. Woollard, Office of Administrative Hearings (OAH), in Sacramento, California, on August 18, 2015, January 4 through 7, 2016, and July 26, 2016.

Demond L. Philson, Deputy Attorney General, represented complainant Kimberly Kirchmeyer, in her official capacity as Executive Director of the Medical Board of California (Board), Department of Consumer Affairs. Investigator Anna Vanderveen was also present.

On August 18, 2015, Jonathan C. Turner, Attorney at Law, appeared on behalf of respondent Thomas Joseph Kaschak, M.D., who was present. Mr. Turner withdrew as respondent's attorney of record and the hearing was continued. On January 4 through 7, 2016, respondent was present and represented himself. Michelle Rivas, respondent's former office manager and custodian of records, was also present. On July 26, 2016, after respondent's request for a continuance was denied, respondent failed to appear further in this proceeding. The hearing proceeded and concluded in his absence.

Oral and documentary evidence was presented. At the conclusion of the evidentiary hearing, the record remained open through October 27, 2016 for written arguments. Complainant's closing argument was received and marked for identification as Exhibit 41. The record closed and the matter was submitted for decision on October 27, 2016.

FACTUAL FINDINGS

1. On November 27, 1989, the Board issued Physician's and Surgeon's Certificate Number G 67586 to respondent. On November 30. 2015, respondent's certificate expired and it is currently in a delinquent status.

2. At the time of the events giving rise to this disciplinary action, respondent held medical staff privileges at Memorial Medical Center (MMC) in Modesto, California. Respondent provided care to his patients at MMC or in other in-patient facilities; however, he also rented an office space close to MMC hospital where he typically saw patients one day per week.

In 2007 and 2008, the Board received consumer complaints regarding respondent's care of patients A.M. and R.M. These complaints were reviewed by the Board's medical consultant Vincent U. Yap, M.D., who recommended that the matters be sent out for expert review. On January 14, 2010, Board Investigator Anna Vanderveen and Dr. Yap conducted an investigatory interview with respondent. Ms. Vanderveen then sent the matters for review by Michael Petersen, M.D. In his expert reports, Dr. Petersen opined that respondent had engaged in extreme departures of the standard of care with patient A.M. and in repeated acts of negligence with patient R.M. pertaining to his postoperative care and medical record keeping.

3. *Accusation*: On September 21, 2010, Linda K. Whitney, in her then-official capacity as Executive Director of the Board, signed and filed the original Accusation to discipline respondent's license under Business and Professions Code sections 2234, subdivisions (b) and (c) (gross negligence/repeated negligent acts), 2266 (negligent patient record keeping [failure to maintain phone logs; failure to timely prepare patient care records]); and 2225.5, subdivision (a)(1) (failure to produce patient records). The factual basis of the Accusation involved respondent's alleged failure to provide appropriate post-surgical care and treatment to patients A.M. and R.M. in the weeks following their surgeries on, respectively, October 27, 2007 and May 20, 2008. The Accusation was served by certified mail on respondent at two addresses, including his then-current address of record with the Board. Both items were returned as "undeliverable" with "no forwarding address."

4. *First Amended Accusation*: On October 16, 2013, complainant signed and filed the First Amended Accusation to discipline respondent's license, based upon the same factual conduct regarding patients A.M. and R.M. as was alleged in the original Accusation and based on substantially the same legal grounds (e.g., gross negligence, repeated negligent acts, and negligent patient record keeping).[1]

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[1] Complainant did not re-allege respondent's failure to comply with Investigator Vanderveen's requests for certified medical records of these patients, under Business and Professions Code section 2225.5, subdivision (a)(1) (civil penalty for failure to produce patient records accompanied by patient's written authorization), as a separate cause for discipline. This matter was ultimately resolved by Citation Order 20-2008-190068.

5. *Motion to Dismiss*: On May 14, 2014, Jonathan Turner, Attorney at Law, filed a Notice of Defense on respondent's behalf. The matter was set for hearing to commence August 18, 2015. On August 7, 2015, Mr. Turner filed a Motion to Dismiss Based on Statute of Limitations, Laches, and Unreasonable Agency Delay Violations, premised on complainant's alleged failure to document service of the original Accusation and subsequent delay. In its opposition, complainant argued that the Accusation was timely served on respondent, that respondent had successfully obtained relief from a Default Decision, and that no new facts had been added to the First Amended Accusation.

By Order dated August 14. 2015, respondent's motion to dismiss was denied without prejudice to renew after completion of the evidentiary hearing.

6. *Evidentiary Hearings*: At the hearings in January 2016, respondent was present and represented himself. By Notice of Continued Hearing dated February 1, 2016, respondent was notified that the hearing would continue on July 26 and 27, 2016.[2]

On July 20, 2016. OAH received respondent's motion for continuance of the July 26, 2016 hearing, based on his status as a "full-time pilot for a major U.S. airline based in Atlanta" and his inability to control his work schedule. He requested that the matter be continued until early 2017. The continuance request was opposed and was denied by order dated July 25, 2016. Respondent was informed of the option to participate in the hearing by telephone, with complainant's consent. (Gov. Code, § 11440.30.) Respondent did not request to appear by phone and he did not appear at the continued hearing.

During the hearing, complainant called the following witnesses: Investigator Vanderveen, patient A.M. and her mother C.M.,[3] and expert witness Michael Shawn Petersen, M.D. Respondent called Board medical consultant Vincent Yap, M.D.

PATIENT A.M.

7. Complainant alleged respondent engaged in gross negligence regarding his post-operative care of 20-year-old patient A.M., who sustained a crush injury to her left hand after being involved in a roll over all-terrain vehicle (ATV) accident. Specifically, complainant alleged that respondent: failed to determine why A.M. missed her initial follow up appointment with him; rescheduled A.M. but did not advise her of the new appointment; and failed to provide a reasonable mechanism for A.M. to contact his office. Complainant

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[2] Respondent and Mr. Philson were ordered to coordinate continuing hearing dates. Mr. Philson subsequently reported that respondent had declined to participate in the selection of continued hearing dates.

[3] To protect confidentiality, initials are substituted for the names of the two patients and their family members and caregivers. The full names of these individuals are contained in the November 28, 2016 Order Re: Confidential Names and Confidential Names List and are subject to the November 16, 2016 Protective Order.

also alleged respondent engaged in negligent patient record keeping because: (1) he failed to respond to C.M.'s numerous telephone calls seeking follow up care for A.M. and never produced his telephone log of patient calls and communications for this time period; and (2) he waited two months before dictating his consultation and operative report for A.M.

8. On October 27, 2007, following the accident, A.M. was taken to MCC where respondent was the on-call orthopedist. That day, respondent performed the following surgical procedures on A.M.'s left hand: (1) an open reduction and internal fixation (ORIF) of the middle phalanx of the left ring finger; (2) an ORIF of the middle and proximal phalanges of the left middle finger; (3) an ORIF of the proximal phalanx of the left index finger; and (4) laceration and nail bed repair. A.M. was placed in a short arm splint and admitted to MCC for observation and postoperative pain control.

9. On October 30, 2007, respondent dictated a "Discharge Summary Report" for A.M., which reflected that A.M. "was instructed to keep the arm elevated, keep the dressing dry, will follow up in the office on 11/06/07 at 3 p.m., given prescription for Norco 10 mg 1 every 4 hours as needed, #50, with one refill. Keflex 500 mg 1 q.i.d., #60." Respondent's final diagnosis was: "Status post open reduction, internal fixation, multiple open fractures involving index through ring finger left hand." Respondent did not dictate his consultation and operative report for A.M.'s October 27, 2007 surgery until December 26, 2007.

10. A.M. was discharged from MCC that day. On discharge, A.M. was provided Discharge Instructions, which notified her of a follow up appointment with respondent on Friday, November 16, 2007, and provided respondent's Modesto office address and telephone number. A.M.'s mother C.M. initially called respondent's office to confirm the date and time for this appointment, because she was aware respondent only had office hours on Tuesdays. It was undisputed that the November 16, 2007 appointment date had been erroneously transcribed from respondent's discharge summary, which set the appointment for Tuesday, November 6, 2007.

11. On December 7, 2007, the Board received a complaint from C.M., who characterized respondent as "competent" in his care and surgery of A.M., but complained he had failed to make himself available for follow up care after A.M.'s discharge from the hospital and that her multiple telephone calls and messages were not returned. C.M. documented her efforts to reach respondent on her calendar, from which she created a timeline provided to the Board with the complaint.

12. As explained in C.M.'s testimony and complaint, voice mail messages could not be left at respondent's office due to a full mail box on October 31 and November 1, 2007; messages were left on respondent's office voice mail without response on November 2, 6, and 7, 2007, when C.M. explained that A.M. was running out of her pain medication; and "urgent" messages were left about this issue three times on November 8, 2007. On November 8, 2007, at 1620 hours, Michelle Rivas called C.M.'s cell phone and said she would discuss this with respondent and would call Walgreens Pharmacy "asap" to have them re-fill A.M.'s prescription. Later on November 8, 2007, C.M. went to Walgreens but no

prescription refill had been approved. C.M. then left voice mail messages, which went unanswered, at respondent's office telephone on November 8 and 9 (marked "urgent").

13. On November 9, 2007, C.M. took A.M. back to MCC's emergency room where A.M. was prescribed a similar medication. C.M. never received any return messages from respondent. On November 16, 2007, C.M. brought A.M. to respondent's office for the follow up appointment described in the Discharge Instructions. The office was locked and the lights were out. C.M. then took A.M. back to MCC, where she advised that three weeks had passed since A.M.'s surgery and asked who should follow up. A patient support nurse suggested that A.M. speak to her primary care doctor for a referral to another orthopedic surgeon. Dr. Wong, the on-call physician, prescribed another 20 tabs of Lortab for A.M.'s pain.

14. On November 19, 2007, C.M. took A.M. to her primary care physician, Dr. Kwon-Hong, for a referral to a different orthopedic surgeon. Because A.M.'s bandage had not been changed since her discharge, Dr. Kwon-Hong and her staff spent considerable effort trying to remove it. Dr. Kwon-Hong described A.M.'s left hand as follows:

> HAND: Left hand and forearm in a partial cast, the dressing appears to be quite dirty and soaked in dry blood. Spent approximately the next four hours trying to take off dressing. Her hand was soaked. However, the dressing was quite adherent to her skin, and due to discomfort, the patient was quite apprehensive about removing her partial cast/bandage. After painstaking attempts, the original dressing was removed, which revealed macerated skin and muscular atrophy. Her 2nd, 3rd, 4th, and 5th digits still appeared to be quite swollen. Original sutures are still in place over the surgical wound, there is quite a bit of crusting and yellowish discharge. The patient virtually had no mobility of her digits. Peripheral pulses are intact.
>
> A&P: Multiple fractures to left hand, status-post ATV in accident. Now patient with post-surgical complications. The patient's case was discussed with Dr. Cavialle [*sic*], he agreed to see this patient immediately. Therefore, as soon as the dressings were removed, the patient... [was] sent to Dr. Cavialle's office.

15. Paul A. Caviale, M.D., is a hand and upper extremity surgeon, who examined A.M. on November 19, 2007, after Dr. Kwon-Hong removed the bandage. In his physical examination of A.M.'s left hand, Dr. Caviale noted that the "tip of the little finger is necrotic. She is extremely painful and teary-eyed. This has been quite an ordeal for her." He diagnosed A.M. with "open fractures, left hand fingers," and recommended she begin gentle range of motion exercises. Dr. Caviale noted that "it looks like there will be a loss of the tip of the little finger. She was informed that there was marked tendon damage of the ring finger and I do not doubt it. She is almost certainly going to need some sort of additional operation

in the future, but what exactly that will be remains to be seen..." He applied a new dressing that day. Dr. Caviale continued to follow A.M. and he performed additional surgery in 2008.

16. C.M. did not recall respondent telling her or A.M. to come to his office on November 6, 2007, and did not recall respondent providing her with a business card with this date written on it. C.M. never received any communications from Ms. Rivas telling A.M. to come in to the office on either Saturday, November 10, 2007, or on Tuesday, November 13, 2007. C.M. denied that A.M. was "drug seeking" after the surgery when she requested a medication refill on November 8, 2007.

17. A.M. testified that C.M. was in charge of all her follow up appointments and communications with respondent's office after her surgery. A.M. never personally called respondent's office or received any telephone calls or messages from anyone at respondent's office, including Ms. Rivas. She had "a lot of pain," took her pain medications and slept to alleviate the pain. She never attempted to remove the bandage herself after surgery. Because the blood and stitching had adhered to the gauze bandage, she had to soak her hand extensively before Dr. Kwon-Hong and her staff could begin trying to remove the bandage. Currently, A.M. has limited mobility in her fingers; she lost the tip of her left pinky finger which is sensitive. She has full feeling in her three other fingers.

18. During the investigation, respondent provided his Tuesday office schedule for November 6, and 13, 2007. These reflected that A.M. missed her November 6, 2007, appointment and was scheduled for an appointment on November 13, 2007. Respondent had no documentation or records to show that A.M. had ever been contacted about this new appointment. Respondent was also asked for patient telephone logs documenting patient phone calls. Respondent never provided any such documents.

PATIENT R.M.

19. Complainant alleged respondent engaged in repeated negligent acts as to his 70-year-old patient R.M., following his May 20, 2008 cemented bipolar hemiarthroplasty of R.M.'s right hip. Specifically, complainant alleged that respondent failed to provide discharge summary instructions for R.M.'s postoperative management; and failed to either provide postoperative follow-up care or make arrangements for R.M. to receive postoperative care from another orthopedic surgeon experienced in hemiarthroplasty. Complainant also alleged respondent engaged in negligent patient record keeping because he failed to respond to R.M.'s numerous telephone calls seeking follow up care and never produced his telephone log of patient calls and communications.

20. Patient R.M. suffered a displaced right femoral neck fracture in a fall on May 19, 2008, and was taken to MCC. As the hospital's on-call orthopedic surgeon that date, respondent assessed R.M. and recommended a cemented bipolar hemiarthroplasty of her right hip. On May 20, 2008, after the admitting physician cleared R.M. for surgery, respondent performed the hemiarthroplasty. R.M. tolerated the surgery with no documented complications. On May 21 and 22, 2008, respondent followed up with R.M. in the hospital.

In postoperative notes, respondent recommended that R.M. continue physical therapy (PT) and indicated she was stable for transfer to a skilled nursing facility (SNF).

21. On May 24, 2008, Angela Quang, M.D., prepared R.M.'s discharge summary, which included a plan to transfer her to a short-term rehabilitation facility, follow up with her primary care physician and with activities recommended by her orthopedic surgeon. Respondent signed, but did not date, an MCC "Inter-Facility Transfer" form, which provided a diagnosis of "fx R hip," listed a suture removal date of June 3, 2008, and indicated R.M. should be evaluated and treated with PT "per protocol," with PWB (partial weight bearing). Respondent noted R.M. "may go to full wt. in 3 weeks. F/U ortho PRN." Respondent did not provide any discharge instructions for R.M.

22. On May 24, 2008, R.M. was transferred to Hy-Lond Convalescent Hospital (Hy-Lond), which was in close proximity to MCC and respondent's office. On May 31, 2008, R.M. was sent to the emergency room for an evaluation of her surgical site. Cultures were obtained that noted heavy growth of mixed skin flora. R.M. was given the antibiotics vancomycin and Rocephin. She remained at Hy-Lond for approximately five weeks until she was discharged to home on June 20, 2008. R.M.'s discharge orders included orders for home PT, but did not include an orthopedic follow up. R.M. believed she needed an x-ray and continued trying to reach respondent.

23. On October 6, 2008, the Nevada State Board of Medical Examiners (Nevada Board) received a complaint from R.M., that respondent never came to see her while she remained at Hy-Lond after her hip surgery. RM reported that her caretaker S.C. had called respondent's Modesto office, as well as his main Reno office, "many times and left messages. No one answered the phone in either office." R.M. further indicated that she needed an x-ray of her hip "but cannot get one without his order" and that she was "really upset and depressed" by respondent's lack of follow up.

24. On October 9, 2008, the Board received R.M.'s complaint from the Nevada Board, which indicated it had no jurisdiction. On November 3, 2008, R.M. signed an Authorization for Release of Patient Health Information form, authorizing respondent to release her medical records to the Board. Neither R.M. nor her caretaker S.C. testified at hearing.

EXPERT OPINION

25. *Michael S. Petersen, M.D.*: Dr. Petersen obtained his medical training at the University of Iowa, College of Medicine and completed his residency in Orthopedic Surgery at the University of Arkansas for Medical Sciences in 1991. He completed fellowships in hand and microvascular surgery at the University of California, San Diego (1991-92) and in shoulder surgery at the Western Sydney Orthopaedic Associates, in Sydney, Australia (1992-1993). From 1994 through 2004, Dr. Petersen was the Chief of Surgery at Woodland Memorial Hospital and practiced hand and upper extremity surgery at the Woodland Clinic Medical Group. From 2004 through 2010, Dr. Petersen practiced hand and upper extremity

surgery at Valley Oak Orthopedics, in Davis, California. Since 2010, Dr. Petersen has practiced orthopedic surgery with Sutter Medical Group. Dr. Petersen has been certified by the American Board of Orthopaedic Surgery since 1996, from which he received a Certificate of Added Qualification in Hand Surgery in 1997.

26. At the Board's request, Dr. Petersen reviewed respondent's care and treatment of patients A.M. and R.M. in light of the allegations in the Accusation. For each of these patients, Dr. Petersen reviewed the complaints, the medical records (from respondent, from MCC and other treating physicians), the initial memorandums from Board medical consultant Dr. Yap, and the CD of respondent's January 14, 2010 interview with the Board.

27. *Opinions regarding Patient A.M.*: In his March 31, 2010 expert report, Dr. Petersen offered opinions in two areas: postoperative follow up and management for a patient with a severe hand injury, and medical record keeping.

A. Postoperative Follow up and Management: Dr. Petersen described the standard of care as follows:

> The standard of care is to arrange for and provide postoperative management after a severe hand injury as encountered in this case.The standard of care includes providing clear and adequate discharge instructions to the patient for followup [*sic*]. Standard also includes making the best effort possible to assure that the patient is aware of these follow up arrangements.

Based on his review of the medical records, Dr. Petersen acknowledged that respondent "did provide discharge orders and the hospital chart and also outlined the follow up plans in his progress notes on the date of discharge. It does appear that there was a transcription error by the nursing staff providing the discharge instruction sheet to the patient so that the patient received the wrong date for the appointment...." While the transcription error could not be attributed to respondent, Dr. Petersen opined:

> However, when the patient failed to return for her first postoperative visit, Dr. Kaschak's office schedule records would indicate that she was assigned a follow up visit the following week. However, he cannot provide any documentation that the patient was contacted any way so that she would be aware of this appointment or that there were any attempts to contact the patient with this new follow up appointment.

In Dr. Petersen's opinion, respondent engaged in an "extreme departure from the standard of care for failing to arrange for and provide adequate postoperative follow up for a severe hand injury."

B. Medical Record Keeping: Dr. Petersen described the standard of care for medical record keeping as follows:

> The standard of care is to keep adequate phone log [*sic*] of patient communication including phone calls from patients and phone calls made to patients. Standard of care also requires that hospital dictation be performed in a timely manner.

In his opinion, respondent engaged in an "extreme departure from the standard of care for lack of proper record keeping and inability to produce these records." Specifically:

> Dr. Kaschak failed to provide a mechanism where this patient could contact his office. Multiple phone calls were made without successful contact. The voice mail was either full and the patient could not leave messages or phone calls were not returned. On one occasion where his office was contacted, the requested prescription was not called into the pharmacy. Dr. Kaschak also failed to dictate the hospital history and physical and operative report until two months after those encounters.

Dr. Petersen's opinion testimony regarding patient A.M. was generally consistent with his expert report. While empathizing with the transcription error that was not within respondent's control, Dr. Petersen reiterated that the standard of care mandates that documented efforts be made to ensure that the patient was aware of the rescheduled postoperative appointment (November 13, 2007). There was no evidence that respondent made any contact with A.M. or responded to any calls by C.M. to ensure appropriate postoperative care for A.M.

28. *Opinions regarding Patient R.M.:* In his March 31, 2010 expert report regarding patient R.M., Dr. Petersen offered opinions in these same two areas.

A. Postoperative Follow up and Management. Dr. Petersen described the standard of care for postoperative follow up of a hemiarthroplasty of the hip as follows:

> Hemiarthroplasty of the hip requires postoperative management by the operating surgeon or arrangement for follow up with another orthopedic surgeon with expertise in hip arthroplasty. Follow up with primary care physician does not meet the standard of follow up care.

In Dr. Petersen's opinion, respondent's failure to provide adequate follow up care for R.M. constituted a "simple departure from the standard of care for not providing adequate postoperative management and follow up following a hip hemiarthroplasty." Specifically, there were:

> ...no discharge instructions from the hospital provided by [respondent]. There were no instructions as far as postoperative management. There were no instructions as far as orthopedic follow up or any arrangements for orthopedic follow up or assessment. Although the patient was requesting an x-ray, an x-ray would not necessarily be required in initial postoperative management of hemiarthoplasty. This would be at the discretion of the orthopedist.

B. Medical Record Keeping: Regarding medical record keeping, Dr. Petersen indicated that the "standard of care is to provide a medical record log of patient phone calls and communications with patients." In R.M.'s case, respondent "was unable to provide any records indicating phone calls made to his office by this patient." In Dr. Petersen's opinion. this constituted "simple departure from the standard of care for failure to provide adequate medical records for tracking patient phone calls."

29. Dr. Petersen's opinion testimony regarding patient R.M. was generally consistent with his expert report. Dr. Petersen acknowledged that some of the notations in respondent's "Inter-Facility Transfer" form for R.M. could be considered to be discharge instructions (e.g., staple removal date, PT, "F/U ortho PRN"). While it was not accurate to say respondent provided no charge instructions, Dr. Petersen explained that this form was not a communication to the patient. Rather, it was a communication between facilities and more specific follow up instructions directed to the patient are required. A "PRN" or "as needed" follow up was not a sufficient discharge instruction for this type of hip surgery, which required a specific follow up either by respondent or via referral to another orthopedic surgeon. There was no evidence that respondent either personally followed up with R.M. or provided her with a specific referral to another orthopedic surgeon.

Dr. Petersen also testified that he based his opinion that respondent did not respond to R.M.'s repeated attempts to contact him on information in the Investigative Report prepared by Investigator Vanderveen, which summarized her interview with R.M. Dr. Petersen had no reason to believe that R.M.'s representation that her caretaker S.C. made repeated attempts to contact respondent as reported to Investigator Vanderveen was inaccurate.

Respondent's Evidence

30. Respondent specializes in orthopedic surgery. He passed the written examination, but has never been board-certified in this area. He is also a commercial pilot. Because respondent failed to participate in the continued hearing on July 26, 2016, neither he nor his office manager Ms. Rivas testified, and he did not provide any expert opinion testimony. Respondent did not provide evidence to support his affirmative defenses and he did not renew his motion to dismiss.

31. Respondent provided several documents which were admitted and are considered to the extent permitted by Government Code section 11513, subdivision (d).[4]

- Wesley Kinzie, M.D., provided a letter of "full support" for respondent, dated July 23, 2015. Dr. Kinzie is an orthopedic surgeon who has known respondent for the past 25 years and has "seen him perform . . . excellent service especially for those that are less fortunate. He has been in emergency room call for many years and again provided a great service to the community in this area..."

- Betty Larrabee, MCC Trauma Case Manager, provided an undated letter thanking respondent for his presentation on Femur Fractures. She indicated that respondent was "enjoyable, definitely knowledgeable, and very professional" in his presentation to the Trauma Grand Rounds.

- Four letters were provided from MCC's Chiefs of Staff confirming respondent's selection and ongoing participation in its Multidisciplinary Trauma Committee for the following years: 1991; April 1, 1992 - March 31, 1993; April 1, 2007 - March 31, 2008; and April 1, 2008 - March 31, 2009.

- Respondent provided his own declaration, signed under penalty of perjury on November 30, 2015, in which he declared that he has provided emergency or urgent orthopedic services at both MCC and Doctors Medical Center in Modesto since 1990; that many of these services were provided for the State of California through Medi-Cal; and that the State has failed to pay its obligations to him for the period from 1997 through 2009, with penalties and interest in an estimated amount in excess of $650,000.

  Respondent further declared that he has attempted to obtain payment and that: "the lack of required medical payments by the State of California significantly impaired the day to day operations and obligations of the medical practice to T. Kaschak, M.D."

Discussion

32. Respondent did not call an expert witness and did not testify on his own behalf. Dr. Petersen was the only expert to testify in this matter.[5] As such, his opinions that

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[4] In pertinent part, Government Code section 11513, subdivision (d), provides that "[h]earsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions."

respondent violated the standard of care in his post-surgical care and treatment of patients A.M. and R.M. and in his record keeping regarding these patients were undisputed. Dr. Petersen's opinions regarding respondent's violations of the standard of care are persuasive with one exception. There was no direct evidence to establish that R.M. or S.C. repeatedly called respondent seeking follow up care. As such, the factual predicate for Dr. Petersen's opinion that respondent engaged in a simple departure from the standard of care by failing to provide adequate medical records tracking patient phone calls on R.M.'s behalf cannot stand. In all other respects, Dr. Petersen's testimony provides clear and convincing evidence to establish the allegations in the First Amended Accusation.

Based on a review of the record as a whole, the public will be protected by revoking respondent's license and placing him on probation, subject to conditions that include completing a medical records course and not engaging in solo practice, for a period of three years.

LEGAL CONCLUSIONS

1. *Purpose of Physician Discipline*: The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) Disciplinary proceedings protect the public from incompetent practitioners by eliminating those individuals from the roster of state-licensed professionals. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

2. *Burden and Standard of Proof*: To revoke or suspend respondent's medical license, the complainant must establish the allegations and violations alleged in the First Amended Accusation by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The requirement to produce clear and convincing evidence is a heavy burden, far in excess of the preponderance of evidence standard that is sufficient in most civil litigation. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

3. Business and Professions Code section 2234 provides that the Board "shall take action against any licensee who is charged with unprofessional conduct." Unprofessional conduct described in section 2234 includes, but is not limited to, gross negligence and repeated negligent acts.

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[5] Respondent unsuccessfully attempted to establish that Dr. Yap had some bias. As Dr. Yap correctly noted, he is not an expert in this area and his role as medical consultant was solely to determine whether the matter should be referred out for expert review.

4. *Gross Negligence*: Pursuant to section 2234, subdivision (b), the Board may discipline a licensee's medical license for gross negligence. Gross negligence is defined as "the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941; *Franz v. Board of Medical Quality Assurance* (1982),31 Cal.3d 124, 138; *Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196.)

As set forth in the Factual Findings and Legal Conclusions as a whole and, particularly, in Factual Findings 25 through 27 and 32, complainant established by clear and convincing evidence that respondent was grossly negligent in his care and treatment of A.M. following her surgery.

5. *Repeated Negligent Acts*: Pursuant to Business and Professions Code section 2234, subdivision (c), the Board may discipline a licensee's medical license for "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. Negligence is conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm. A physician is required to exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by other prudent physicians under similar circumstances. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 998.)

As set forth in the Factual Findings and Legal Conclusions as a whole and, particularly, in Findings 25, 28, 29 and 32, complainant established by clear and convincing evidence that respondent engaged in repeated negligent acts or omissions in the care and treatment of R.M. by: (1) failing to provide discharge summary instructions for R.M.'s postoperative management; and (2) failing to either provide postoperative follow-up care or make arrangements for R.M. to receive postoperative care from another orthopedic surgeon experienced in hemiarthroplasty.

6. *Inadequate Medical Records*: Pursuant to Business and Professions Code section 2266, "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

A. As set forth in the Factual Findings and Legal Conclusions as a whole and, particularly, in Factual Findings 25, 27 and 32, complainant established by clear and convincing evidence that respondent failed to maintain adequate and accurate medical records for patient A.M. by: (a) failing to maintain and produce patient communication logs including telephone logs; and (b) failing to timely dictate his consultation note and operative report.

B. As set forth in the Factual Findings and Legal Conclusions as a whole and, particularly, in Findings 29 and 32, complainant did not establish by clear and convincing evidence that respondent failed to respond to R.M.'s numerous telephone calls seeking follow up care.

ORDER

Physician's and Surgeon's Certificate Number G 67586 issued to respondent Thomas Joseph Kaschak, M.D., is hereby REVOKED; however, revocation is STAYED, and respondent is placed on three (3) years of probation, with the following terms and conditions:

1. **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 equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program 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 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.

2. **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 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.

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

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

4. **Supervision of Physician Assistants:** During probation, respondent is prohibited from supervising physician assistants.

5. **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.

6. **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.

7. **General Probation Requirements:** Compliance with Probation Unit
Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

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

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

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

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

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

8. **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.

9. **Non-practice While on Probation:** Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. 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 a clinical training 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 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; and General Probation Requirements.

10. **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. Upon successful completion of probation, respondent's certificate shall be fully restored.

11. **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.

12. **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.

13. **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.

DATED: November 28, 2016

DocuSigned by:
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MARILYN A. WOOLLARD
Administrative Law Judge
Office of Administrative Hearings