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

In the Matter of the Accusation Against:	)	
Vincent Luvern Anthony, M.D.	)	**Case No. 800-2016-024564**
Physician's and Surgeon's Certificate No. A 96566	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on March 26, 2020.

IT IS SO ORDERED February 25, 2020.

MEDICAL BOARD OF CALIFORNIA

By: _____
Ronald H. Lewis, M.D., Chair
Panel A

XAVIER BECERRA
Attorney General of California
JUDITH ALVARADO
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **VINCENT LUVERN ANTHONY, M.D.** **1711 West Temple Street, #7200** **Los Angeles, CA 90026** **Physician's and Surgeon's Certificate No. A96566,** Respondent.	Case No. 800-2016-024564 OAH No. 2019051292 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Christine J. Lally (Complainant) is the Interim Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Vladimir Shalkevich, Deputy Attorney General.

2. Respondent Vincent Luvern Anthony, M.D. (Respondent) is represented in this proceeding by attorney Richard J. Ryan, Esq., whose address is: 500 N. Brand Blvd., Suite 950 Glendale, CA 91203.

3. On or about July 28, 2006, the Board issued Physician's and Surgeon's Certificate No. A 96566 to Vincent Luvern Anthony, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2016-024564, and will expire on January 31, 2022, unless renewed.

JURISDICTION

Accusation No. 800-2016-024564 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 April 23, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

4. A copy of Accusation No. 800-2016-024564 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2016-024564. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary 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. 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 prima

facie basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

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

CONTINGENCY

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

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

12. 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 Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 96566 issued to Respondent VINCENT LUVERN ANTHONY, M.D. is hereby publicly reprimanded pursuant to Business and Professions Code section 2227. This Public Reprimand is issued in connection with Respondent's actions as set forth in Accusation No. 800-2016-024564.

IT IS FURTHER ORDERED that Respondent comply with the following:

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

A medical record keeping course taken after the acts that gave rise to the charges in the 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. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the

Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. VIOLATION OF THIS AGREEMENT. Failure to comply with any term or condition of this Agreement is unprofessional conduct in violation of Business and Professions Code section 2234. If Respondent violates this Agreement in any respect, the Board may file an accusation and, after a hearing, discipline Respondent's license for unprofessional conduct in violation of section 2234.

ACCEPTANCE

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

DATED: 1/14/20

VINCENT LUVERN ANTHONY, M.D.
Respondent

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

DATED: 1/12/20

RICHARD J. RYAN, ESQ.
Attorney for Respondent

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ENDORSEMENT

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

DATED: 1/13/20

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH ALVARADO
Supervising Deputy Attorney General

VLADIMIR SHALKEVICH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2016-024564

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO April 23 2019
BY D. Richards ANALYST

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

In the Matter of the Accusation Against: VINCENT LUVERN ANTHONY, M.D. 1711 West Temple Street, #7200 Los Angeles, California 90026 Physician's and Surgeon's Certificate A 96566, Respondent.	Case No. 800-2016-024564 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On July 28, 2006, the Board issued Physician's and Surgeon's Certificate Number A96566 to Vincent Luvern Anthony, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2020, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code 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."

5. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent Vincent Luvern Anthony, M.D. is subject to disciplinary action under section 2234, Subdivision (b) of the Code in that he grossly negligent in the care and treatment of a single patient. The circumstances are as follows:

8. At all times relevant to the allegations herein, July 1 through July 3, 2016, Respondent was the director of the subacute care unit at California Hospital Medical Center (CHMC) in Los Angeles, California. Respondent's duties as the subacute unit director were about to end, and a different physician was about to take over these duties. Respondent was covering for the incoming physician through the Fourth of July, 2016, holiday.

9. The Patient whose care and treatment is the subject of this Accusation, was a 35-year-old male who previously suffered a debilitating stroke. The patient was transferred from Kindred Hospital to the subacute care unit at CHMC on or about July 1, 2016 at approximately 1800 hours, at which time he became Respondent's patient. Respondent was made aware ahead of this transfer by the CHMC subacute unit case manager. Although he was aware of the incoming patient, and acknowledged that this patient became his responsibility upon admission to CHMC, Respondent had none, or very limited, clinical information about him. Respondent did not personally review the patient's case or the transfer orders from Kindred. Respondent did not receive any communication from the transferring physician, and he did not reach out to speak with the transferring physician. In a later communication to the Board investigators, Respondent, through his attorney, claimed that the nursing staff at CHMC made a unilateral decision to admit the patient to Respondent's care without his authorization and without a physician confirming whether or not the patient was stable for transfer. These factors should have prompted Respondent to visit the patient as soon as possible upon the patient's admission to CHMC.

10. At the time of transfer to CHMC, the patient was suffering from the effects of a major stroke, which occurred approximately five months prior. He was suffering from severe oropharyngeal dysphasia, characterized by lack of volitional movements and inability to swallow, and was unable to manage his secretions. The patient had a history of sleep apnea, which

required him to breathe through a tracheostomy during night time. He received nutrition through a feeding tube, and voided through a catheter.

11. Respondent was contacted by CHMC nursing staff, and spoke with a nurse at approximately 10:00 p.m. on July 1, 2016. At that time, Respondent ordered that all of the previous medical orders from the transferring facility be continued until he could visit the patient and physically examine him. At the time, Respondent did not know the details of the prior orders from the transferring facility. His conversation with CHMC nursing staff was no longer than three minutes, and it was not documented in the patient's record. Respondent did not visit and/or examine this patient on July 1, 2016.

12. The nursing staff at CHMC contacted Respondent several times between midnight and approximately 2:00 a.m. on July 2, 2016, seeking additional orders based on the patient's family requests for medications or treatments that were not included in the Kindred transfer orders, or were not accurately transcribed from Kindred transfer orders. Still, Respondent did not visit and examine this patient at CHMC on July 2, 2016.

13. On July 3, 2016, the patient had trouble breathing and his condition began to worsen. CHMC nursing staff began attempts to reach Respondent to obtain an order for a breathing treatment at approximately 11:20 a.m. At 11:44 a.m., before Respondent could be reached, a rapid response team[1] was summoned to the patient's room. Respondent spoke to the CHMC nursing staff at approximately 11:55 a.m., and ordered the patient transferred to the CHMC Intensive Care Unit (ICU). The patient was transferred to the ICU, where he remained Respondent's patient, with nursing staff continuing to page and update Respondent on the patient's condition. Respondent, however, did not visit and examine his patient after the transfer to ICU on July 3, 2016, and did not make, or attempt to make, or document making or attempting to make, any arrangement to transfer the care of the patient to another physician.

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[1] A "rapid response team" is a patient safety intervention team summoned to the patient's bedside when a patient demonstrates signs of imminent clinical deterioration.

14. At 1:45 p.m. on July 3, 2016, a "Code Blue"[2] was called for the patient. The nursing staff at CHMC unsuccessfully attempted to contact Respondent at 1:45 p.m. and again at 1:47 p.m. A CHMC nurse left a message that the patient was "coding" with Respondent's call service at 1:59 p.m. The nursing staff was able to reach Respondent by phone at 2:07 p.m. This telephone call lasted 15 minutes. After the "Code Blue" was initiated, the patient was revived by the code team after receiving two electrical shocks. A second "Code Blue," however, was initiated at 2:13 p.m., and this time the patient could not be revived. The patient's time of death was called at 3:16 p.m. on July 3, 2016. Respondent did not visit and did not examine this patient at CHMC on July 3, 2016, or at any time during the patient's hospitalization at CHMC.

15. Respondent was the doctor of record for the patient during the patient's hospitalization at CHMC. Respondent did not write any note in the patient's chart. Respondent did not document an Admission History and Physical, did not document any progress note, did not prepare a Transfer Summary (to ICU), did not prepare a Discharge Summary, and did not prepare a Death Note. There is also no documentation of any communication with the ICU medical staff upon transfer to ICU on July 3, 2016, even though Respondent's phone records show that communications took place.

16. Respondent completed the Death Certificate for this patient, and declared that the patient's proximate cause of death was "septic shock." This is in disagreement with the Code Team's documented conclusion that the patient's death was caused by a massive pulmonary embolism. Without any clinical documentation from Respondent, it is impossible to understand his rationale for choosing septic shock as the cause of the patient's death. Respondent did not document any reason why he drew a conclusion that was different from that of the Code Team.

17. The call logs provided by Respondent support the reports by the nurses and the patient's family that Respondent does not return calls every time he is paged. Respondent himself, through his attorney, stated that he tells the nurses to page him every 15 minutes until he

[2] A "Code Blue" is an emergency situation announced in a hospital or institution in which a patient is in cardiopulmonary arrest, requiring a team of providers (sometimes called a 'code team') to rush to the specific location and begin immediate resuscitative efforts.

responds. Having this as a personal standard is potentially unsafe for the patients. It discourages communication between doctor and nurses.

18. After the patient's transfer to the ICU, Respondent's failure to visit and examine him at the CHMC ICU, or alternatively, to arrange and document the transfer of the patient's care to another doctor, constitutes an extreme departure from the standard of care under the circumstances described in paragraphs 8 through 17 herein.

19. Respondent's failure to make any documentation in the patient's chart under the circumstances described in paragraphs 8 through 17 herein, constitutes a separate and distinct extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

20. Respondent Vincent Luvern Anthony, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in the care and treatment of his patient. The circumstances are as follows:

21. The allegations of paragraphs 8 through 17 are incorporated herein by reference.

22. Respondent's failure to visit and examine the patient prior to the patient's transfer to the ICU at CHMC under the circumstances described in paragraphs 8 through 17 herein, constitutes a departure from the standard of care.

23. After the patient's transfer to ICU, Respondent's failure to visit and examine him at the CHMC ICU, or alternatively, to arrange and document the transfer of the patient's care to another doctor, constitutes a departure from the standard of care under the circumstances described in paragraphs 8 through 17 herein.

24. Respondent's failure to make any documentation in the patient's chart under the circumstances described in paragraphs 8 through 17 herein, constitutes a departure from the standard of care.

25. Respondent's failure to document the reasons for his conclusion that the patient's proximate cause of death was septic shock constitutes a departure from the standard of care.

26. Respondent's failure to promptly communicate with the CHMC nursing staff, requiring them to page him every 15 minutes until he responds, is a simple departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

27. Respondent Vincent Luvern Anthony, M.D. is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records in his care and treatment of the patient. The circumstances are as follows:

28. The allegations of paragraphs 8 through 17 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 A 96566, issued to Vincent Luvern Anthony, M.D.;

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

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

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

DATED: April 23, 2019

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

Complainant

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