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

In the Matter of the Accusation Against: David D. Johnson, M.D. Physician's & Surgeon's Certificate No G11110 Respondent	Case No. 800-2016-027676

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 April 16, 2021.

IT IS SO ORDERED March 19, 2021.

MEDICAL BOARD OF CALIFORNIA

By: Ronald H Lewis, MD

Ronald H. Lewis, M.D., Chair
Panel A

XAVIER BECERRA
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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: **DAVID D. JOHNSON, M.D.** **P.O. Box 991844** **Redding, CA 96099-1844** **Physician's and Surgeon's Certificate No. G 11110** Respondent.	Case No. 800-2016-027676 OAH No. 2019080760 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Ryan J. Yates, Deputy Attorney General.

2. Respondent David D. Johnson, M.D. (Respondent) is represented in this proceeding by attorney Stewart C. Altemus, whose address is: Altemus & Wagner, 1890 Park Marina Drive, Suite 200, Redding, CA 96001. On or about August 23, 1965, the Board issued Physician's and

Surgeon's Certificate No. G 11110 to David D. Johnson, M.D. (Respondent). The Physician's and Surgeon's Certificate expired on November 30, 2017, and has not been renewed.

JURISDICTION

3. Accusation No. 800-2016-027676 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 July 17, 2019. Respondent timely filed his Notice of Defense contesting the Accusation.

4. A copy of Accusation No. 800-2016-027676 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. 800-2016-027676. Respondent has also carefully read, fully discussed with his 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. "Respondent does not contest that, at an administrative hearing, complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2016-027676 and that he has thereby subjected his license to disciplinary action."

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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 imposition of discipline 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. Respondent agrees that in the event of a future Accusation being filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2016-027676 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving respondent in the State of California. Respondent shall not be deemed to have admitted the truth or correctness of the allegations included in Accusation No. 800-2016-027676 for any other purpose.

12. 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.

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

DISCIPLINARY ORDER

1. PUBLIC REPRIMAND. IT IS HEREBY ORDERED that Physician's and Surgeon's

Certificate No. G 11110, issued to Respondent David D. Johnson, M.D. is publicly reprimanded pursuant to California Business and Professions Code, section 2227 , subdivision (a)(4). This public reprimand, which is issued in connection with Respondent's care and treatment of Patients A and B, as set forth in Accusation No. 800-2016-027676, is as follows:

> "Respondent is charged with gross negligence, repeated negligent acts, and failure to maintain adequate and accurate records, and general unprofessional conduct. On August 14, 2016, Respondent became involved in the care and treatment of Patient A and failed to immediately involve a formal cardiology consultation. On August 15, 2016, Respondent performed a bedside Transesophageal Echocardiography (TEE) study, where he reviewed the screen imaging, in real time. He additionally ordered images to be produced for further review. Prior to Respondent's shift ending at 5:00 P.M., Respondent failed to review the post-study images from the TEE test, in detail, and failed to provide oncoming physicians with details on whether or not he based his interpretation of the TEE test on a more detailed post study review. Additionally, prior to leaving, Respondent failed to retain a formal cardiology consultation for Patient A.
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> "It is additionally alleged that between August 15, 2016, and October 8, 2016, Respondent failed to take adequate and accurate medical records regarding his care and treatment of Patient B, Patient C, Patient D, and Patient F."

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

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its

designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. VIOLATION OF THIS AGREEMENT. If Respondent fails to enroll, participate in, or successfully complete the educational program(s) or course(s) within the designated time period. Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the educational program(s) or course(s) has been completed. Failure to successfully complete the educational program(s) or course(s) outlined above shall constitute unprofessional conduct and is grounds for further disciplinary action."

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Stewart C. Altemus. 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: 1/18/2020

DAVID D. JOHNSON, M.D.
Respondent

I have read and fully discussed with Respondent David D. Johnson, 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: 1/18/2020

STEWART C. ALTEMUS
Attorney for Respondent

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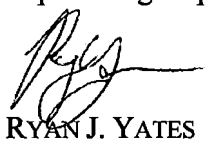
ENDORSEMENT

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

DATED: January 19, 2021

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General



RYAN J. YATES
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2016-027676

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 17 2019
BY: Patricia Arroyo ANALYST

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

In the Matter of the Accusation Against: **David D. Johnson, M.D.** **P.O. Box 991844** **Redding, CA 96099-1844** **Physician's and Surgeon's Certificate** **No. G 11110** Respondent.	Case No. 800-2016-027676 **A C C U S A T I O N**

PARTIES

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

2. On or about August 23, 1965, the Medical Board issued Physician's and Surgeon's Certificate No. G 11110 to David D. Johnson, 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 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 118 of the Code states, in pertinent part:

"(a) The withdrawal of an application for a license after it has been filed with a board in the department shall not, unless the board has consented in writing to such withdrawal, deprive the board of its authority to institute or continue a proceeding against the applicant for the denial of the license upon any ground provided by law or to enter an order denying the license upon any such ground.

"(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 licensee on any such ground.

"(c) As used in this section, 'board' includes an individual who is authorized by any provision of this code to issue, suspend, or revoke a license, and 'license' includes 'certificate,' 'registration,' and 'permit.'"

5. Section 2427(a) of the Code states, in pertinent part:

"(a) Except as provided in Section 2429 , a license which has expired may be renewed at any time within five years after its expiration on filing an application for renewal on a form prescribed by the licensing authority and payment of all accrued renewal fees and any other fees required by Section 2424 . If the license is not renewed within 30 days after its expiration, the licensee, as a condition precedent to renewal, shall also pay the prescribed delinquency fee, if any. Except as provided in Section 2424 , renewal under this section shall be effective on the date on which the renewal application is filed, on the date on which the renewal fee or accrued

renewal fees are paid, or on the date on which the delinquency fee or the delinquency fee and penalty fee, if any, are paid, whichever last occurs. If so renewed, the license shall continue in effect through the expiration date set forth in Section 2422 or 2423 which next occurs after the effective date of the renewal, when it shall expire and become invalid if it is not again renewed."

6. Section 2227 of the Code provides in pertinent part 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.

7. Section 2234 of the Code states, in pertinent part:

"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.

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8. 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)

9. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence during the care and treatment of Patient A.[1]

10. Patient A was a sixty-five (65) year old male with a history of hypertension, stroke without deficits, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD) and peripheral vascular disease (PVD). In March of 2016, Patient A had received coronary artery bypass,[2] bilateral carotid artery endarterectomy[3] and bilateral iliofemoral stents[4] surgeries. Patient A had an elevated white blood cell count and acute chronic kidney injury.

11. On or about August 7, 2016 through August 9, 2016, Patient A developed progressively worsening respiratory failure and septic shock, requiring emergent intubation and vasopressor[5]support. On August 11, 2016, a transthoracic echocardiogram[6] (TTE) was performed, which demonstrated preserved left ventricular ejection fraction[7] of 50-60%, with

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[1] Patient names and information have been redacted to protect privacy. All witnesses will be identified in discovery.

[2] Coronary artery bypass surgery, also known as coronary artery bypass graft surgery, and colloquially heart bypass or bypass surgery, is a surgical procedure to restore normal blood flow to an obstructed coronary artery.

[3] Carotid endarterectomy is a surgical procedure performed by vascular surgeons used to reduce the risk of stroke by correcting stenosis in the common carotid artery or internal carotid artery. Endarterectomy is the removal of material on the inside of an artery.

[4] Bilateral iliofemoral stents are placed in the iliofemoral vein—located near the hip—in order to improve the flow of blood.

[5] Vasopressors are drugs or other agents which cause the constriction of blood vessels.

[6] A TTE is a noninvasive procedure, which uses high frequency soundwaves to create a moving picture of the heart through the chest wall. This test is used to examine suspected problems with the valves or chambers of the heart, as well as the heart's ability to pump blood.

[7] Preserved ejection fraction occurs when heart muscle contracts normally but the ventricles do not relax as they should during ventricular filling.

moderate aortic regurgitation[8] and new moderate to severe mitral regurgitation, which was attributed heart failure.

12. On or about August 13, 2016, Patient A was transferred to Mercy Medical Center Redding (Mercy) for continued critical care management and more thorough cardiac evaluation and workup of possible endocarditis[9] and shock. Patient A was first seen by Mercy's nighttime intensivist, whose plan of care included the continuation of invasive mechanical ventilatory support, pressor support with broad spectrum antibiotics for presumed health care acquired pneumonia, and repeat echocardiogram; as well as cardiology consultation, as needed, for non-STEMI[10] heart attack and mitral regurgitation.

13. On or about August 14, 2016, Respondent became involved in the care and treatment of Patient A. Although Patient A was presenting with major complicated cardiac issues, Respondent failed to immediately involve a formal cardiology consultation.

14. On or about August 15, 2016, at approximately 1:00 P.M., Respondent performed a bedside Transesophageal echocardiography[11] (TEE) study. Based on the immediate results of the TEE study, Respondent concluded that there were no vegetations[12] seen on aortic or mitral valves, and that there was persistent mitral regurgitation but mild aortic regurgitation. There was no mention in Patient A's medical records of the need for the TEE study.

15. Later in the afternoon, Patient A was taken off the ventilator, and Respondent's shift ended at approximately 5:00 P.M. Respondent gave bedside reports to the oncoming nighttime intensivist and to the intensivist for the following day. Prior to leaving his shift, Respondent failed to review the images from the TEE test, in detail, following the original test, due to the images being unavailable before the end of his shift. Additionally, Respondent did not provide

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[8] Aortic regurgitation is due to incompetence of the aortic valve or any disturbance of the valvular apparatus resulting in the diastolic flow of blood into the left ventricle.

[9] Endocarditis is the infection of the inner lining of the heart chambers and heart valves.

[10] A Non-STEMI is a type of heart attack. Non-STEMI stands for Non-ST-elevation myocardial infarction. ST refers to the ST segment, which is part of the electrocardiogram (EKG) heart tracing used to diagnose a heart attack, thereby making a Non-STEMI heart attack invisible to an EKG.

[11] Transesophageal echocardiography (TEE) is a test that produces pictures of the heart. TEE uses high-frequency sound waves to make detailed pictures of the heart and the arteries that lead to and from it.

[12] A vegetation is a mass of bacteria growth occurring in one of the heart valves.

the oncoming physicians with details regarding whether or not he based his interpretation of the TEE test on a more detailed post study review. Moreover, prior to departing from Mercy, Respondent did not retain a formal cardiology consultation for Patient A.

16. Prior to leaving his shift, Respondent failed to timely report and document the TEE study on Patient A. Following the aforementioned TEE study, Respondent should have documented the procedure in a standardized procedure report, which contains the indication/diagnosis, time out, description of procedures, notable findings, specimens, and any related complications. The report should additionally have contained patient demographics and a systematic description of cardiac structures and measurements, as well as statements of other abnormalities. Furthermore, due to Patient A's critical illness, Respondent should have expedited the report in order to manage Patient A's illness, based on the findings of the TEE study. Instead, Respondent's only documentation regarding the results of the TEE study was in his daily progress note for August 15, 2016, which stated that there were no vegetations seen on aortic or mitral valves, and that there was persistent mitral regurgitation but mild aortic regurgitation. Respondent subsequently left town for the next four (4) days.

17. From August 16, 2016, to August 20, 2016, Patient A continued to be in cardiogenic shock and had worsening renal injury with rising blood urea nitrogen to creatinine ratio.[13] Due to Patient A's worsening condition, a cardiologist was consulted. The cardiologist reviewed the images of the TEE performed by Respondent and noted that the mitral valve looked structurally normal without any clear evidence of endocarditis, however, there was significant abnormality in the aortic valve leaflets[14] with severe aortic regurgitation and evidence of possible aortic valve ring abscess with fistula[15]and back flow to the left atrium. This contributed to the observation of severe mitral regurgitation, which was out of proportion with Patient A's previous history of

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[13] The ratio of Blood urea nitrogen to creatinine is usually between 10:1 and 20:1. An increased ratio may be due conditions such as congestive heart failure or dehydration.

[14] A leaflet is the heart tissue attached to a heart valve designed to stop the backflow of blood.

[15] A fistula is an abnormal connection between two hollow spaces, such as blood vessels, and intestines. Fistulas are usually caused by injury or surgery, but they can also result from an infection or inflammation.

relatively normal mitral valve and left ventricular function. The cardiologist concluded that the patient had aortic valve endocarditis with the aforementioned complications, and either mitral valve endocarditis or a possible fistula causing the flow of blood into the left atrium.

18. The cardiologist contacted cardiovascular surgeons at higher-level facilities in order to transfer Patient A, however, Patient A's condition worsened, and on August 22, 2019, Patient A died.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

19. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts during the care and treatment of Patients A, as more fully described in paragraphs 9 through 18, above, and those paragraphs are incorporated by reference as if fully set forth herein.

Patient B:

20. Patient B was a sixty-five (65) year old man with history of spinal fusion[16] and laminectomy,[17] who was admitted to Mercy following a fall from a bed. While at Mercy, he was found to have abscesses due to staph aureus infection in his thoracic spine, and underwent surgery. His hospital stay was further complicated by ongoing sepsis, due to recurrent spinal osteomyelitis,[18] which resulted in surgery. He additionally had a traumatic bladder laceration, which required repair, and persistent anemia—which required multiple transfusions—which resulted from a psoas muscle hematoma.[19] This was in addition to recurrent episodes of respiratory failure, as well as renal injury, delirium, deconditioning, and a clostridium difficile[20] infection.

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[16] Spinal fusion is a surgical procedure used to correct problems with the small bones in the spine (vertebrae). It is essentially a "welding" process. The basic idea is to fuse together two or more vertebrae so that they heal into a single, solid bone.

[17] Laminectomy is surgery in which the back part of a vertebra which covers the spinal canal is removed. Also known as decompression surgery, laminectomy enlarges the spinal canal to relieve pressure on the spinal cord or nerves.

[18] Spinal osteomyelitis refers to an infection of the vertebral body in the spine.

[19] Psoas muscle hematoma is a rare complication of the anticoagulation therapy, which can cause abdominal or lumbar pain, muscle dysfunction and sometimes nerve palsy.

[20] Clostridium difficile is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon.

21. On or about October 5, 2016, Respondent became the attending intensivist in the care and treatment of Patient B. Between October 6, 2016, and October 8, 2016, Respondent documented daily plans of care, using the assistance of a scribe. During that time period, Respondent failed to make adequate and accurate medical records. For example, in Patient B's daily progress notes, Respondent repeated sentences and made numerous punctuation and spelling errors. In Patient B's progress note for October 8, 2016, Respondent documented, "10/7 He had no difficulty with extubation, and can go to minimal nasal oxygen to avoid atelectasis."[21] This note was immediately followed by an identical sentence, except it was preceded by "10/8." Although Respondent listed Patient B's medical problems and associated plan of care in the "Subjective" section of Patient B's progress notes, Respondent also incompletely copied and pasted the identical notes into the "Assessment/Plan" section. Respondent additionally failed to list a discussion of ventilator settings and plans for extubation in the appropriate "Respiratory Failure" section of Patient B's progress notes. Instead, these notes were listed under the "Coronary artery disease post 05/15," section of the progress notes.

Patient C:

22. Patient C was a seventy-four (74) year old man with history of coronary artery disease, sleep apnea, severe aortic stenosis (a narrowing of the aortic valve opening), hyperlipidemia (too much fat in the blood), alcohol abuse, and prostate cancer. Respondent became involved in Patient C's care and treatment, after Patient C underwent a transurethral resection of bladder neck.[22]

23. Between October 5, 2016, and October 8, 2016, Respondent documented daily plans of care, using the assistance of a scribe. During that time-period, Respondent failed to make adequate and accurate medical records. For example, in the October 8, 2016, progress notes, Respondent noted under the "Alcohol abuse" heading, "10/6 Coronary angiography[23] and

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[21] Atelectasis is collapse of lung tissue with loss of volume.

[22] Transurethral resection of the bladder neck incision are accepted methods in the treatment of obstructive prostatic hyperplasia. (prostate gland enlargement, which can block the flow of urine out of the bladder) The procedure involves making a cut through the neck of the bladder using an electric "spike"passed through a telescope along the patient's urethra.

[23] Coronary angiography is a procedure that uses a special dye (contrast material) and x-rays to see how blood flows through the arteries of a patient's heart.

evaluation of the aortic valve were carried out today with his prior stent open and no coronary lesions requiring intervention. The aortic valve area is estimated at 1 cm^2 by pullback, and [the attending cardiologist] plans pending the echo and catheter findings...for another opinion on timing of valve intervention." Respondent copied and pasted the identical terminology under the "Aortic stenosis severe" heading.

24. Respondent additionally made incomplete notes in reference to Patient C's problem list and plan under the "assessment/plan" section of Patient C's progress notes. This is followed immediately by duplicative language under the "Subjective" section of the notes. This resulted in great difficulty in understanding Patient C's plan of care for a given day.

25. Respondent also failed to enter complete progress notes regarding diagnoses reflecting Patient C's clinical problems. For example, a ventilator management plan was listed under the "Torsades des points," "alcohol abuse," and "severe aortic stenosis" headings, however, there was no clear documentation of Patient C's respiratory failure, ecoli, and sepsis diagnoses.

26. Furthermore, in Patient C's October 6, 2016, progress notes, Respondent entered an attestation to critical care time into the "Subjective" section of the progress notes. However, it should have been entered at the end of the note.

Patient D:

27. Patient D was a fifty-one (51) year old woman with a history of hypertension, sickle cell trait, chronic kidney disease, congestive heart failure, and methamphetamine abuse. On or about October 5, 2016, Patient D was admitted to Mercy for intracranial bleeding.

28. On or about October 5, 2016, Respondent became involved in the care and treatment of Patient D. Between October 5, 2016, and October 7, 2016, Respondent documented daily plans of care, using the assistance of a scribe. During that time-period, Respondent failed to make adequate and accurate medical records. For example, Respondent entered duplicative notes, regarding the assessment and plan, under the "Subjective" section of Patient D's progress notes. Additionally, in Patient D's October 6, 2016, progress notes, Respondent made two (2) sections labeled "Assessment/Plan," with largely identical problem lists.

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Patient E:

29. Patient E was a sixty-two (62) year old male with a history of severe emphysema, pulmonary hypertension, tobacco use, and coronary artery disease. On or about September 30, 2016, Patient E was admitted to Mercy for refractory respiratory failure and septic shock.

30. On or about October 1, 2019, Respondent became involved in the care and treatment of Patient E. Between October 5, 2016, and October 8, 2016, Respondent documented daily plans of care, using the assistance of a scribe. During that time-period, Respondent failed to make adequate and accurate medical records. For example, Respondent entered duplicative notes, regarding the assessment and plan, under the "Subjective" section of Patient E's progress notes. Additionally, in Patient E's October 6, 2016, progress notes, Respondent made two (2) sections labeled "Assessment/Plan," with largely identical problem lists.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

31. Respondent's license is subject to disciplinary action under section 2266 of the Code, in that he failed to maintain adequate and accurate medical records relating to his care and treatment of Patients A, B, C, D, and E as more fully described in paragraphs 9 through 29, above, and those paragraphs are incorporated by reference as if fully set forth herein.

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 No. G 11110, issued to David D. Johnson, M.D.;

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

3. Ordering David D. Johnson, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: July 17, 2019

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

SA2019102296
Johnson Accusation MBC.docx