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

In the Matter of the Accusation Against: Vivian Magdi Gindi, M.D. Physician's & Surgeon's Certificate No A 95838 Respondent	Case No. 800-2017-035685

DECISION

The attached Stipulated Settlement and Disciplinary Order for Public Reprimand 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 June 4, 2021.

IT IS SO ORDERED May 7, 2021.

MEDICAL BOARD OF CALIFORNIA

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

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
COLLEEN M. MCGURRIN
Deputy Attorney General
State Bar Number 147250
California Department of Justice
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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: **VIVIAN MAGDI GINDI, M.D.** **1110 North Western Ave, Suite 201** **Los Angeles, CA 90029** **Physician's and Surgeon's Certificate No. A 95838** Respondent.	Case No. 800-2017-035685 OAH No. 2019080393 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER FOR PUBLIC REPRIMAND**

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 current Executive Director of the Medical Board of California (Board). This action was brought by Kimberly Kirchmeyer, the past Executive Director of the Board, solely in her official capacity and are represented in this matter by Xavier Becerra, Attorney General of the State of California, by Colleen M. McGurrin, Deputy Attorney General.

2. Respondent Vivian Magdi Gindi, M.D. (Respondent) is represented in this proceeding by attorney Peter R. Osinoff, Esq., from Bonne Bridges Mueller O'Keefe & Nichols

whose address is: 355 South Grand Avenue, Suite 1750, Los Angeles, CA 90071-1562.

3. On or about June 7, 2006, the Board issued Physician's and Surgeon's Certificate No. A 95838 to Vivian Magdi Gindi, 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. 800-2017-035685, and will expire on January 31, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-035685 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 16, 2019. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-035685 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-035685. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of her 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 her; the right to present evidence and to testify on her 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.

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-035685, if proven at a hearing, constitute cause for imposing discipline upon her

Physician's and Surgeon's Certificate.

10. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations in the Seventh Cause for Discipline contained in Accusation No. 800-2017-035685, a true and correct copy which is attached hereto as Exhibit A, hereby gives up her right to contest those charges, and that she has subjected her Physician's and Surgeon's Certificate No. A 95838 to disciplinary action.

11. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

12. 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 her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her 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.

13. 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.

14. 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:

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 95838 issued to Respondent VIVIAN MAGDI GINDI, M.D. is publically reprimanded pursuant to Business and Professions Code section 2227, subdivision (a)(4), as follows and under the following terms and conditions:

PUBLIC REPRIMAND

1. You are hereby publically reprimanded for failure to maintain adequate and accurate medical records regarding the care and treatment of Patient 1, in November 2016 through July 2017, as set forth in Accusation No. 800-2017-035685, in violation of Business and Professions Code sections 2234, subdivision (c), and 2266.

CONDITIONS OF PUBLIC REPRIMAND

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s), which shall not be less than 60 hours that must be completed within one (1) year of the effective date of this Decision. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 85 hours of CME of which 60 hours were in satisfaction of this condition.

3. 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.

4. VIOLATION OF PUBIC REPRIMAND. Failure to fully comply with any term or condition of this public reprimand shall be cause for further discipline against Respondent's license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Peter R. Osinoff, 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 freely, voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 1/25/2021

VIVIAN MAGDI GINDI, M.D.
Respondent

I have read and fully discussed with Respondent Vivian Magdi Gindi, 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: 1/30/2021

PETER R. OSINOFF, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: February 1, 2021

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

Colleen M. McGurrin

COLLEEN M. MCGURRIN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-035685

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 16 2019
BY ANALYST

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

In the Matter of the Accusation Against: **Vivian Magdi Gindi, M.D.** **1110 North Western Ave, Suite 201** **Los Angeles, CA 90029** **Physician's and Surgeon's Certificate No. A 95838,** Respondent.	Case No. 800-2017-035685 **ACCUSATION**

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 June 7, 2006, the Medical Board issued Physician's and Surgeon's Certificate Number A 95838 to Vivian Magdi Gindi, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2020, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"..."

5. 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.

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"(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."

6. 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 diagnoses followed by an act or omission medically appropriate for that negligent diagnoses of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnoses, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnoses 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."

7. 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."

FACTUAL ALLEGATIONS

1. Respondent is employed by Hollywood Cross Medical Clinic ("clinic"), which is owned and operated by her parents, M.G. and N.G.

2. Patient 1,[1] a 58 year old female, began receiving care from the Respondent at the clinic on or about November 2016.

3. Respondent had office visits with Patient 1 on approximately twelve occasions since Patient 1 began her care at the clinic on September 1, 2016.[2]

4. On September 22, 2016, Patient 1 provided a blood sample for a nontreponemal test ordered by Dr. M.G. She tested positive for rapid plasma reagin (RPR) status[3] with quantification of 1:2. Handwritten notation documented "pt got treatment 1985 or 1990."

5. On November 16, 2016, Respondent saw Patient 1 for neck pain and ingrown toenails bilaterally on the big toes. The patient had a blood pressure of 150/100, but Patient 1 reported that she had not taken her medications that day. Respondent's diagnoses of Patient 1

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[1] For privacy purposes, the patient in this Accusation is referred to as Patient 1, with the identity of the patient disclosed to Respondent in discovery.

[2] Patient 1 was also seen at the clinic by the other two doctors on various occasions. The visits as summarized in the Factual Allegations focus on the care provided to Patient 1 by Respondent.

[3] A rapid plasma reagin (RPR) test is a blood test used to screen for syphilis. Syphilis is a sexually transmitted infection that can be fatal if left untreated.

included cellulitis, myalgia, diabetes with complications, vitamin D deficiency, gastroesophageal reflux disease (GERD), ingrown toenail, hypertension (HTN), and a history of RPR positive in 1985. Abnormal findings included tenderness upon palpation bilateral trapezius. Patient 1 was prescribed antibiotics, nonsteroidals and oral hypoglycemics.

6. On November 22, 2016, Respondent saw Patient 1 for insomnia after recent "traumatic event/attack." No further details were provided. No patient safety evaluation was documented. No physical exam was documented. A "good support system" was documented. RPR positive was again documented under diagnoses. Follow up was as needed.

7. On November 29, 2016, Respondent saw Patient 1 for abdominal gas. Patient 1's blood pressure was 130/80. Diagnoses included insomnia, GERD, diabetes mellitus (DM), dyslipidemia, vitamin D deficiency, HTN, RPR positive with treatment in 1990, and constipation. The patient was prescribed Ambien, oral hypoglycemics, ranitidine, antihypertensives, oral nonsteroidals, Linzess and Creon. Follow up was as needed.

8. On December 8, 2016, Respondent saw Patient 1 who came in complaining of itching (pruritis[4]) for 3 days. No blood pressure or skin test was documented. The patient was prescribed Atarax.[5]

9. On December 12, 2016, Respondent saw Patient 1 for hip pain and constipation. The patient was diagnosed with sciatica and constipation. She was prescribed Neurontin, oral steroids, Colace, and a high fiber diet. She was advised to begin the Linzess prescription. She was also given a dexamethasone[6] intramuscular shot. Follow up was not documented.

10. On December 23, 2016, Respondent saw Patient 1 again for a burn on her hand. The patient had a blood pressure of 170/90. Respondent prescribed silver sulfadiazine, Motrin, and a refill of amlodipine.

11. On January 25, 2017, Respondent saw Patient 1 for low back pain with radiation to the left leg. Tenderness to palpation of low back region was noted. The patient was given oral

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[4] Pruritis is the medical terminology for severe itching. It can be associated with a number of disorders, including dry skin, skin disease, pregnancy, and rarely, cancer.

[5] Atarax is a hydroxyzine tablet used to treat itching caused by allergies.

[6] Dexamethasone is a type of glucocorticoids, which are anti-inflammatory, immunosuppressant, and decongestant drugs.

and topical nonsteroidals and orthopedic referrals.

12. On January 31, 2017, Respondent saw Patient 1 for sore throat, cough, bilateral hand numbness, and neck pain. Abnormal physical exam was not legible. Diagnoses included bronchitis, neuritis and possibly neuropathy. Plan included antibiotics, antitussive, gabapentin, ibuprofen. Follow up was not clear.

13. On February 15, 2017, Respondent saw Patient 1 for left low back pain radiating down to left leg. Diagnoses included sciatica and insomnia. Referral to orthopedics was planned and follow up was as needed.

14. On March 14, 2017, Patient 1 returned for medication refills. She complained of lower back pain radiating down to the left leg, nasal congestion, dry cough, itching. Diagnoses and plan were largely illegible. It was unclear which doctor saw her.

15. On March 27, 2017, Respondent saw Patient 1 for itchiness and pain in the left leg. Abnormal exam of oropharynx and lumbar region was documented. Diagnoses included lumbago and an illegible word involving tonsils. Plan included nonsteroidals, antibiotics, and antihistamines. Follow up was as needed.

16. On July 6, 2017, Respondent and Dr. M.G. saw Patient 1 for vaginal dryness, fungus on toe, dysuria and sensation of incomplete voiding. No genitourinary exam or toe exam were documented. Three illegible words were charted under diagnoses and plan was left blank. Referral to podiatry was documented.

17. On July 27, 2017, Respondent saw Patient 1 who came in for a medication refill. Respondent claims that she saw Patient 1 and told her that her medication had already been refilled.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Failure to Properly Manage Hypertension)

18. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code in that she was grossly negligent in her care and treatment of Patient 1 for hypertension. The circumstances are as follows:

19. Complainant refers to and, by this reference, incorporates Paragraphs 8 through 17,

above, as though set forth fully herein.

20. Blood pressure goals are dependent on a patient's cardiovascular risk profile and other comorbid conditions. However, generally, the standard of care provides that patients with an average blood pressure of $\geq$ 140/90 in the office should be initiated on treatment. Once the blood pressure goal is determined for an individual patient, it should be documented and clearly communicated to the patient. Evaluation should be performed to determine the extent of target organ damage, if any, as well as the presence of other cardiovascular risk factors. Lifestyle factors that could potentially contribute to hypertension should be addressed. Medications, such as nonsteroidal anti-inflammatory drugs (NSAIDs), which can potentially elevate blood pressure readings, should be identified and used with caution.

21. Respondent's care and treatment of Patient 1, as set forth in Paragraphs 8 through 17, above, includes acts and/or omissions which constitutes an extreme departure from the standard of care. The circumstances are as follows:

22. Despite the patient's blood pressure readings on multiple occasions being out of range, Respondent failed to properly assess end organ damage, discuss lifestyle modifications, or educate the patient on compliance and risk of uncontrolled hypertension.

23. Respondent also prescribed NSAIDS to Patient 1 on at least five occasions between November 16, 2016 to March 27, 2017. When Respondent first prescribed NSAIDS to the patient on November 16, 2016, the patient had a history of blood pressure readings at or above 140/90 and a history of noncompliance. Patient 1's blood pressure registered 150/100 on November 16, 2016 and 170/90 on December 23, 2016. There are no records of discussions of the potential risks with the patient, or an evaluation of alternatives. As such, Respondent failed to properly assess and communicate the risks of prescribing NSAIDS to a patient with high blood pressure.

24. Respondent's acts and/or omissions as set forth in Paragraphs 8 through 17 and 22 through 23, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence – Failure to Appropriately Diagnose the Cause of Pruritis)

25. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code in that she was grossly negligent in her care and treatment of Patient 1 for her complaint of itching. The circumstances are as follows:

26. Complainant refers to and, by this reference, incorporates Paragraphs 8 through 17, above, as though set forth fully herein.

27. Pruritis is a common disorder that may be a manifestation of a spectrum of disease processes, ranging from benign to those associated with significant morbidity. The standard of care for a patient presenting with pruritis involves a careful history and physical examination, particularly of the skin. Select laboratory studies can be useful for obtaining a diagnosis.

28. Respondent's care and treatment of Patient 1, as set forth above in Paragraphs 8 through 17, includes acts and/or omissions which constitutes an extreme departure from the standard of care. The circumstances are as follows:

29. Patient 1 presented to the clinic on several occasions for pruritis, and presented to the Respondent for these issues on December 8, 2016 and March 27, 2017. On December 8, 2016, the patient reported three days of itching at the time she was seen. Respondent did not record a physical exam or note alarm features to rule out life-threatening conditions. The lack of diagnostic workups precluded an evaluation of the underlying condition for which the patient required treatment. Instead, a medication, Atarax, was prescribed with no further workups scheduled or planned.

30. Respondent's acts and/or omissions as set forth in Paragraphs 8 through 17 and 29, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore, cause for discipline exists.

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THIRD CAUSE FOR DISCIPLINE

(Gross Negligence – Failure to Appropriately Diagnose the Cause of and Appropriately Treat Excess Intestinal Gas)

31. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code in that she was grossly negligent in her care and treatment of Patient 1 for excess intestinal gas. The circumstances are as follows:

32. Complainant refers to and, by this reference, incorporates Paragraphs 8 through 17, above, as though set forth fully herein.

33. Initial evaluation of excess gas should include a history and physical to identify alarm features, such as nocturnal abdominal pain, systemic symptoms including weight loss or fever, organomegaly, and vomiting. A dietary history should also be taken, focusing on gas-producing foods and beverages. Most patients can be treated conservatively with dietary modifications. Patients with GERD may require acid-suppressive therapy.

34. Respondent's care and treatment of Patient 1, as set forth above in Paragraphs 8 through 17, includes acts and/or omissions which constitutes an extreme departure from the standard of care. The circumstances are as follows:

35. Patient 1 presented to the clinic on several occasions for excess gas and constipation. Respondent saw Patient 1 for these issues on November 29, 2016, December 12, 2016, and July 16, 2017, but no diagnostic workup was performed. During these visits, Respondent prescribed Patient 1 with Ranitidine, Linzess, and Creon. On January 16, 2019, Respondent stated during her interview[7] that she prescribed Linzess because she believed it would help with constipation, which she believed was caused by poor diet. Respondent also stated she prescribed Creon to the patient "because she is diabetic", and "they have poor digestion." However, Linzess is not approved for every type of constipation and Creon is not FDA approved in aiding indigestion in diabetics. Without a diagnostic workup to identify the underlying cause of symptoms presented, these medications were prescribed without clear medical indications.

36. Respondent's acts and/or omissions as set forth in Paragraphs 8 through 17 and 35,

[7] Respondent was interviewed by Investigators for the Board on January 16, 2019.

above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore, cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence – Failure to Appropriately Manage Positive RPR)

37. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code in that she was grossly negligent in her care and treatment of Patient 1 for her positive nontreponemal (RPR) test results. The circumstances are as follows:

38. Complainant refers to and, by this reference, incorporates Paragraphs 8 through 17, above, as though set forth fully herein.

39. RPR is a screening nontreponemal test for syphilis. If the test returns positive, the standard of care involves a confirmatory treponemal test to rule out false positives. In patients with a history of treated syphilis, the presence of a positive RPR can indicate a new infection, an evolving response to recent treatment, treatment failure, or the presence of a serofast state. Healthcare providers are mandated by the California Department of Public Health to report syphilis cases.

40. Respondent's care and treatment of Patient 1, as set forth above in Paragraphs 8 through 17, includes acts and/or omissions which constitutes an extreme departure from the standard of care. The circumstances are as follows:

41. Respondent documented Patient 1's positive RPR with history of treatment on multiple occasions. A confirmatory treponemal test should have been planned and conducted. During the interview with Respondent, she seemed unaware that she needed to work up such cases. Since a patient testing positive for RPR after treatment may have a new infection, be a treatment failure, or be in a serofast state, Respondent's lack of follow up testing presents a public health concern. She also appeared to be unaware that she needed to report a positive test to the California Department of Public Health.

42. Respondent's acts and/or omissions as set forth in Paragraphs 8 through 17 and 41, above, whether proven individually, jointly, or in any combination thereof, constitute gross

negligence pursuant to section 2234, subdivision (b), of the Code. Therefore, cause for discipline exists.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence – Failure to Appropriately Treat Sciatica)

43. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code in that she was grossly negligent in her care and treatment of Patient 1 for sciatica. The circumstances are as follows:

44. Complainant refers to and, by this reference, incorporates Paragraphs 8 through 17, above, as though set forth fully herein.

45. The standard of care for a patient presenting with symptoms of sciatica involves a focused history and physical examination to identify alarming features that require imaging or other evaluations to rule out infectious, inflammatory, or neoplastic causes. Low risk patients should be treated conservatively with nonnarcotic analgesics, such as NSAIDs or acetaminophen, and temporary activity modification. Reassessment should be carried out in two to four weeks to evaluate for need of other treatment options or further workup. Systemic or epidural glucocorticoids are options for patients who have persistent severe radicular symptoms that are refractory to conservative therapy. A tailored, stepwise approach that involves increasing and decreasing medications as necessary, with periodic reviews and further workups, would minimize adverse effects from excessive treatment.

46. Respondent's care and treatment of Patient 1, as set forth above in Paragraphs 8 through 17, includes acts and/or omissions which constitutes an extreme departure from the standard of care. The circumstances are as follows:

47. Respondent's history and physical on Patient 1 did not provide information on alarm features for patient's sciatica. Respondent prescribed both NSAIDS as well as glucocorticoids to a patient with uncontrolled hypertension, GERD and known noncompliance. This prescribing behavior was excessive and increased the risk of adverse drug events, potential for drug-drug

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interactions, possibility of prescribing cascades[8] and further compliance issues. There was no documentation of a risk/benefit/alternatives discussion of glucocorticoid[9] injections provided in the clinic. There was no plan for periodic reviews.

48. Respondent's acts and/or omissions as set forth in Paragraphs 8 through 17 and 47, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore, cause for discipline exists.

SIXTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

49. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that she engaged in repeated acts of negligence in the care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 17, above, as though fully set forth herein. The circumstances are as follows:

50. Despite the patient's blood pressure readings on multiple occasions being out of range, Respondent failed to properly assess end organ damage, discuss lifestyle modifications, or educate the patient on compliance and risk of uncontrolled hypertension.

51. Respondent also prescribed NSAIDS to Patient 1 on at least five occasions between November 16, 2016 to March 27, 2017. When Respondent first prescribed NSAIDS to the patient on November 16, 2016, the patient had a history of blood pressure readings at or above 140/90 and a history of noncompliance. Patient 1's blood pressure registered 150/100 on November 16, 2016 and 170/90 on December 23, 2016. There are no records of discussions of the potential risks with the patient, or an evaluation of alternatives. As such, Respondent failed to properly assess and communicate the risks of prescribing NSAIDS to a patient with high blood pressure.

52. Patient 1 presented to the clinic on several occasions for pruritis, and presented to the

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[8] Prescribing cascade is a process whereby the side effects of drugs are misdiagnosed as symptoms of another problem, resulting in further prescriptions and further side effects and unanticipated drug interactions, which itself may lead to further misdiagnoses and further symptoms.

[9] Dexamethasone, which was administered by injection, is a form of glucocorticoid.

Respondent for these issues on December 8, 2016 and March 27, 2017. On December 8, 2016, the patient reported three days of itching at the time she was seen. Respondent did not record a physical exam or note alarm features to rule out life-threatening conditions. The lack of diagnostic workups precluded an evaluation of the underlying condition for which the patient required treatment. Instead, a medication, Atarax, was prescribed with no further workups scheduled or planned.

53. Patient 1 presented to the clinic on several occasions for excess gas and constipation. Respondent saw Patient 1 for these issues on November 29, 2016, December 12, 2016, and July 16, 2017, but no diagnostic workup was performed. During these visits, Respondent prescribed Patient 1 with Ranitidine, Linzess, and Creon. On January 16, 2019, Respondent stated during her interview that she prescribed Linzess because she believed it would help with constipation, which she believed was caused by poor diet. Respondent also stated she prescribed Creon to the patient "because she is diabetic", and "they have poor digestion." However, Linzess is not approved for every type of constipation and Creon is not FDA approved in aiding indigestion in diabetics. Without a diagnostic workup to identify the underlying cause of symptoms presented, these medications were prescribed without clear medical indications.

54. Respondent's history and physical on Patient 1 did not provide information on alarm features for patient's sciatica. Respondent prescribed both NSAIDS as well as glucocorticoids to a patient with uncontrolled hypertension, GERD and known noncompliance. This prescribing behavior was excessive and increased the risk of adverse drug events, potential for drug-drug interactions, possibility of prescribing cascades and further compliance issues. There was no documentation of a risk/benefit/alternatives discussion of glucocorticoid injections provided in the clinic. There was no plan for periodic reviews.

55. Respondent's acts and/or omissions as set forth in paragraphs 8 through 17 and 50 through 54, above, whether proven individually, jointly, or in any combination thereof, constitute repeated acts of negligence pursuant to section 2234, subdivision (c), of the Code. Therefore cause for discipline exists.

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SEVENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

56. Respondent is subject to disciplinary action under section 2266 of the Code for failing to maintain adequate and accurate records relating to her care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 17, above, as though 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 Number A 95838, issued to Vivian Magdi Gindi, M.D.;

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

3. Ordering Vivian Magdi Gindi, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED:
July 16, 2019

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

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