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

In the Matter of the First Amended Accusation Against: Ronnie Isaac Mimran, M.D. Physician's & Surgeon's Certificate No. A 90574 Respondent.	Case No. 800-2018-046464

DECISION

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

This Decision shall become effective at 5:00 p.m. on March 11, 2022.

IT IS SO ORDERED February 9, 2022.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

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

In the Matter of the Accusation Against:

RONNIE ISAAC MIMRAN, M.D.,

Physician's and Surgeon's Certificate No. A 90574

Respondent.

Agency Case No. 800-2018-046464

OAH No. 2021070457

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on November 30, December 1, and December 2, 2021, by videoconference.

Deputy Attorney General Caitlin Ross represented complainant William Prasifka, Executive Director of the Medical Board of California.

Attorney John H. Dodd represented respondent Ronnie Isaac Mimran, M.D., who was present for the hearing.

The matter was submitted for decision on December 2, 2021.

FACTUAL FINDINGS

1. The Medical Board of California issued Physician's and Surgeon's Certificate No. A 90574 to respondent Ronnie Isaac Mimran, M.D., on March 23, 2005. At the hearing this active certificate was scheduled to expire November 30, 2022.

2. Acting in his official capacity as Executive Director of the Board, complainant William Prasifka signed an accusation against respondent on February 11, 2021. Respondent requested a hearing. On June 8, 2021, complainant signed a first amended accusation.

3. Complainant alleges that respondent committed unprofessional conduct in three ways, all relating to his treatment of a single patient.

a. Respondent performed spinal surgery on the patient in July 2016, allegedly without addressing a critical abnormality that pre-surgical magnetic resonance imaging (MRI) had identified. Because he had not inspected and evaluated this abnormality at his first surgical opportunity, respondent performed a second surgery in February 2017.

b. The patient experienced headaches and other symptoms after the February 2017 surgery that suggested a cerebrospinal fluid (CSF) leak. Respondent allegedly failed to document proper physical examination to evaluate these symptoms and failed to address the symptoms adequately. A CSF leak existed, which respondent did not diagnose or treat.

c. Respondent engaged in text messaging with the patient over several months. These messages included casual, personal communications that allegedly undermined their professional relationship.

Education and Professional Experience

4. Respondent received his medical degree in 1999, in California. He completed an internship in general surgery in 2000, followed by a residency in neurological surgery in 2005, both in Florida. During his residency, respondent also completed a fellowship in minimally invasive spinal surgery.

5. Respondent returned to California after his residency and joined a neurological surgery practice in Danville in July 2005. Although his practice's business organization has changed, respondent remains in private practice. He performs scheduled surgeries (mostly spinal) two days per week, and also performs emergency surgeries when he is on hospital call.

6. Respondent became board-certified in neurological surgery in 2009 and remained board-certified at the time of the hearing.

7. Respondent holds surgical privileges at a few East Bay hospitals and surgical centers. Since 2015, he has been the medical director for neurosurgery at Eden Medical Center in Castro Valley. He expects beginning in January 2022 to serve as department chair.

8. Respondent has taught many continuing education courses about spinal surgery techniques. He has authored several publications and holds two patents for surgical instruments.

Repeat Spinal Surgeries

9. Respondent's first consultation with the patient occurred on March 26, 2014. She described pain in her low back and lower extremities, chiefly on the left side but "occasionally into right calf and foot."

10. At the patient's appointment on March 26, 2014, respondent reviewed a radiology report from a May 2, 2013, MRI study of the patient's lumbar spine. Between the patient's fourth ("L4") and fifth ("L5") lumbar vertebrae, the report described a "Broad-based central and left paracentral disc protrusion . . . measuring 4 mm. It is tightening the left lateral recess and seems to be impinging on the left L5 nerve root." Respondent's own notes from his March 26, 2014, visit with the patient summarize this study as showing "transitional anatomy at lumbosacral junction. Degenerative Disc Disease at L4/5 with disc protrusion and neurologic compression, modic changes L>R."

JULY 2016 SURGERY

11. Respondent recommended surgery to the patient in 2014, but she did not pursue his recommendation at that time. She returned to respondent on May 16, 2016, because her back and bilateral leg pain had worsened. Respondent ordered a new MRI, to evaluate the patient's then-current condition for possible surgery.

12. The patient had this follow-up MRI on May 27, 2016. The radiologist's report from this study states that the radiologist compared these May 2016 images to images from a December 2013 MRI study, not to images from the May 2013 study described above in Finding 10. No MRI report or images from December 2013 were in evidence.

13. The radiologist's report states that the May 2016 images show "Redemonstration of right paracentral disc sequestration measuring 7 x 8 mm, slightly more prominent than the [December 2013] exam. It is touching and displacing the right L5 nerve root." The report also says, "Previously seen left paracentral 4 mm dorsal disc bulge has improved, with no obvious mass effect on the exiting left L5 nerve." Under "IMPRESSION," the radiologist reiterates, "Redemonstration of right paracentral

disc sequestration at L4-5 touching the right L5 nerve. Left paracentral disc protrusion at L4-5 has improved."

14. Respondent saw the patient on June 13, 2016, to consult with her about plans for surgery. Under the heading "Imaging," his notes from that visit identify the May 2016 MRI, but state, "L4/5 degenerative disc disease with modic changes and collapse, bilateral foraminal disease with lumbar disc herniation, L>R." Respondent's notes do not refer to any "right paracentral disc sequestration" potentially affecting the patient's right L5 nerve root, and they do not refer to any changes between May or December 2013 and May 2016 in the appearance of the patient's left paracentral L4-5 disc protrusion.

15. Respondent has offered inconsistent explanations for the discrepancy between his own summary of the May 2016 MRI (as reflected in his chart notes from June 13, 2016) and the radiologist's summary (as reflected in the May 2016 MRI report). In an interview with Board investigators on June 25, 2020, respondent stated incorrectly that the radiologist in May 2016 had "remarked about L5 pressure very specifically on the left." At the hearing, respondent testified that he "appreciated" the right-sided disc sequestration near the L5 nerve root. He also testified, however, that in his own personal review of the May 2016 images, he saw nothing corresponding to the radiologist's report of a "right paracentral disc sequestration . . . touching and displacing the right L5 nerve root."

16. Respondent performed a surgical transforaminal lumbar interbody fusion (TLIF) between the patient's fourth and fifth lumbar vertebrae on July 26, 2016. His surgical notes do not state explicitly that respondent exposed and explored the right L5 nerve root during this procedure. Similarly, the notes do not state either that respondent identified a disc fragment (or other abnormality) in this location

corresponding to the radiologist's description, or that he looked for something to explain the radiologist's finding but found nothing. Finally, if respondent did look for and see a disc fragment at or near the patient's right L5 nerve root, his notes do not explain any clinical judgment he may have exercised in deciding to leave the fragment in place rather than to remove it.

17. In discussing this July 2016 surgery, respondent has made inconsistent statements about what he did, if anything, to investigate possible impingement on the patient's right L5 nerve root. In his interview with Board investigators, he said that he "probably would have probed" this area, but that he did not "remember very specifically." He also stated in his interview, as well as in testimony, that the usual protocol for this surgery necessarily would have exposed the patient's right L5 nerve root clearly to his view. He testified at one point that he had seen no calcified disc fragment at this location during the July 2016 surgery, but at another point that he had seen such a fragment but had chosen not to remove it. Respondent's contradictory statements about his actions and decisions before and during the patient's July 2016 surgery do not add meaningful information to his contemporaneous surgical note.

FEBRUARY 2017 SURGERY

18. The patient's low back and leg pain persisted after her July 2016 surgery. On December 22, 2016, the patient had another MRI of her lumbar spine. The radiologist's report compares these images to the studies in December 2013 and May 2016, stating that "asymmetry at the right L5 nerve . . . is unchanged" and noting that an unusual item there "was previously thought to have been an extruded disc fragment or sequestered disc." The December 2016 radiology report noted the additional possibility that the item near the right L5 nerve root was a "schwannoma" (a

type of nerve sheath tumor) and recommended "correlation with the previous surgical findings."

19. After further consultation with respondent, the patient elected to have a second surgery to identify and possibly to remove the abnormality that persisted near her right L5 nerve root. This surgery occurred on February 23, 2017.

20. Respondent's report from the February 2017 surgery states that he removed scar tissue at the margin of the right-side "superior L5 lamina," and that "under this the MRI finding was seen." Specifically, in "the axilla of the [right L5] nerve root, there was what appeared to be a calcified disk herniation." Respondent removed this calcified disk herniation, which "had worn through some of the dura and created a very thin spot." He also removed other "large fragments of disk combined with bone."

EXPERT OPINIONS

21. Complainant presented expert testimony by Jeffrey Dembner, M.D., a board-certified neurological surgeon with considerable experience performing TLIF and similar spinal surgeries. Respondent presented expert testimony by Laurence M. Shuer, M.D., also a board-certified neurological surgeon who has considerable experience both performing TLIF and similar spinal surgeries and in training surgical residents (including Dr. Dembner).

22. Dr. Dembner testified that he reviewed both the radiologist's report and the images from the May 2016 MRI described above in Findings 12 and 13. He concurs with the radiologist's statement that the images showed an item adjacent to the right L5 nerve root that was likely a disc sequestration. In his own report, Dr. Dembner describes the May 2016 MRI as showing "a disc fragment that has migrated caudal to

the disc space at L4-5 and sits posterior to the cephalad L5 vertebral body and medial to the right L5 pedicle."

23. Dr. Dembner's opinion is that the standard of care for a neurological surgeon is to review relevant diagnostic imaging and to address identified pathologies during surgery. He believes that respondent's failure during the patient's July 2016 surgery to identify this disc fragment and either to remove it or to document a clinical decision to leave it in place is an extreme departure from the standard of care.

24. In Dr. Dembner's opinion, respondent's departure from the standard of care with respect to the patient's July 2016 surgery harmed the patient by delaying surgical intervention that might have lessened her leg pain, and by exposing her to the risks inherent in a second surgery. Although the patient's leg pain ultimately continued even after her February 2017 surgery, Dr. Dembner does not believe that the patient's pain necessarily would have resolved if respondent had examined the disc fragment during her July 2016 surgery. He acknowledged that if respondent had examined this disc fragment in July 2016, he might have chosen not to remove it, in part because of the risk of damaging other structures to which it had adhered (as described in Finding 20). Dr. Dembner acknowledged as well that if the fragment had been compressing the patient's right L5 nerve root since before December 2013, it might have caused lasting damage to the nerve root by July 2016, which would have continued causing pain even after the fragment's removal.

25. Dr. Shuer testified that he also had reviewed the May 2016 MRI images and had seen nothing resembling a right paracentral disc sequestration near the L5 nerve root. He made no effort to explain why the radiologist's report about these May 2016 images described such an abnormality, or why both this report and the later report about the December 2016 MRI images characterized this abnormality as having

been present since December 2013. Dr. Shuer did not testify expressly as to what, if anything, he believes respondent should have done to resolve the apparent discrepancy between what respondent saw in the May 2016 MRI images and what the radiologist saw. His testimony implies, however, that he believes that the standard of care allows a neurological surgeon simply to disregard a radiologist's interpretation of an MRI study if the neurological surgeon does not concur with that interpretation.

26. Dr. Shuer agrees with Dr. Dembner that the standard of care for a neurological surgeon is to review relevant diagnostic imaging and to address identified pathologies during surgery. Because he believes that diagnostic imaging before the patient's July 2016 surgery gave respondent no reason to consider a disc sequestration compressing the right L5 nerve root, however, he does not believe that respondent departed from the standard of care in failing to look specifically for such an abnormality or to document having looked specifically for it.

27. Dr. Shuer also testified that he believes that respondent's July 2016 TLIF procedure necessarily would have exposed the axilla of the patient's right L5 nerve root to respondent's view, and that if any disc fragment had been present in this location respondent would have seen it. Even so, he testified as well that a neurological surgeon may overlook a disc fragment during surgery, or may exercise clinical judgment by deciding not to remove it, without necessarily departing from the standard of care.

ANALYSIS

28. With respect to the May 2016 MRI study's implications for respondent's surgical planning and decision-making, Dr. Dembner's opinion is persuasive and Dr. Shuer's is not. Whether or not respondent himself saw, or should have seen, a

probable disc sequestration affecting the right L5 nerve root on the May 2016 MRI images, he obtained and should have reviewed a radiologist's report identifying this abnormality as a significant finding in light of the patient's subjective complaints. His failure to plan to address this finding during surgery was an extreme departure from the standard of care.

29. The expert opinions by Dr. Shuer regarding respondent's actions during surgery and his documentation of those actions, summarized above in Findings 25 through 27, reflect and depend on assumptions that the evidence does not support. In particular, Dr. Shuer assumes that the May 2016 MRI images and radiologist's report gave respondent no reason during the patient's July 2016 surgery to look for or to document having looked for a disc sequestration pressing on the right L5 nerve root. This assumption is incorrect, as stated in Findings 13 and 22. Likewise, Dr. Shuer's opinion that respondent could have overlooked the disc fragment during the July 2016 surgery without departing from the standard of care assumes incorrectly that pre-surgical diagnostic imaging did not identify this very fragment as a likely contributor to the patient's symptoms. Finally, Dr. Shuer assumes that the calcified disc fragment respondent saw and removed in February 2017 was not present during the patient's July 2016 surgery, and that its appearance on the December 2016 MRI represented "new pathology." These assumptions also are incorrect, as stated in Findings 12, 13, 18, and 22. Because Dr. Shuer's opinion about respondent's decisions and documentation during the July 2016 surgery reflects and incorporates these incorrect assumptions, it is not persuasive.

30. Dr. Dembner's opinion, as summarized in Findings 23 and 24, is persuasive.

a. The calcified disc fragment that respondent removed from the axilla of the patient's right L5 nerve root during her second surgery in February 2017 was present before her first surgery in July 2016.

b. The patient's pre-surgical imaging in May 2016 showed the fragment, and the radiologist who interpreted those images called it out as significant, but respondent did not look for it during the July 2016 surgery.

c. Because he did not notice the fragment during the July 2016 surgery, respondent made no decision at that time regarding whether its removal would be clinically appropriate.

d. Because he did not recognize before or during the July 2016 surgery that the disc fragment was present, and did not evaluate its clinical impact at that time, respondent had no surgical findings to correlate with the December 2016 MRI report when he received it. Instead, respondent performed a second surgery on the patient in February 2017 to inspect and evaluate an abnormality that he could have and should have evaluated (and documented having evaluated) during the first surgery. Respondent's decisions exposed the patient unnecessarily a second time to the risks attendant to spinal surgery, and delayed unnecessarily a procedure that had the potential to alleviate the patient's distress.

e. This course of action was an extreme departure from the standard of care for neurological spinal surgery.

CSF Leak Following February 2017 Surgery

31. Within a few days after her discharge from the hospital after her February 2017 surgery, the patient complained to respondent of a "severe headache."

Respondent immediately suspected that the dural "thin spot" he had observed during the surgery was leaking CSF. He advised the patient that if so, her headache probably would improve if she lay down, and suggested "a couple days of bedrest."

POST-OPERATIVE EXAMINATIONS

32. The patient's first in-person post-operative examination occurred on March 7, 2017. Respondent noted her report that her headache was "improving," but that she continued to experience "light pressure to head." He also documented that her surgical incision had healed.

33. At the patient's next post-operative examination on April 7, 2017, respondent's note states that she complained of continuing daily headaches and "fogginess." She also stated that headaches were limiting her ability to walk for exercise. The note describes no other discussion of the nature, severity, or frequency of the patient's headaches, or of any strategies (such as lying down) that the patient might have tested for relieving them. The visit note repeats the statement that the patient's surgical incision had healed.

34. Respondent referred the patient for post-operative physical therapy on April 7, 2017. He also referred her for consultation to a pain management specialist.

35. The patient saw respondent next on May 31, 2017. According to his note, she said that her leg pain had improved, but that she continued to experience leg pain when sitting and that leg pain sometimes would awaken her at night. The patient also mentioned headaches, which she believed were due to an ongoing CSF leak. This note again describes no further discussion of the nature, severity, or frequency of the patient's headaches, and does not describe the condition of the patient's surgical incision at this visit.

36. Between April 7 and May 31, the patient consulted with the pain management specialist respondent had recommended. The medical records in evidence do not include any records about the patient from that provider.

37. The patient's last office visit with respondent occurred on July 14, 2017. His notes state that the patient reported having discontinued physical therapy "due to continued swelling at the incision site and severe pain after sessions." She also reported that she continued "to feel headaches that she associated to [CSF] leak." Like the visit note from May 31, this note describes no further discussion of the nature, severity, or frequency of the patient's headaches, and does not describe the condition of the patient's surgical incision. As a follow-up plan, respondent's note states "Consider spinal cord stimulator. Return to [pain management specialist] if interested for pain management. . . . Follow up as needed."

38. The patient did not follow up further with respondent. Instead, in August 2017 she consulted Kulveen Sachdeva, M.D., a neurologist. Contemporaneous records describing the patient's self-reports to Dr. Sachdeva were not in evidence, but Dr. Sachdeva ordered an MRI of the patient's lumbar spine. This study occurred on September 20, 2017, and showed a subcutaneous "fluid collection" near the location of the patient's prior spinal surgeries, "consistent with a dural tear with a [CSF] leak." Later treatment confirmed that the fluid was CSF, and that it had accumulated under the patient's skin because of a dural tear near her surgical site.

39. Respondent is confident that although the patient described headaches consistently in the several months after her February 2017 surgery, she never described "postural" headaches that occurred when she was upright but resolved when she lay down. If she had, he testified, he would have ascribed her headaches right away to a CSF leak. Because she did not, however, he not only did not believe

after her March 2017 post-operative examination that she likely had a clinically significant CSF leak, but did not document anything about her headaches other than her reports that they persisted.

40. Respondent also is confident that he examined the patient's surgical scar on May 31 and July 14, but neither saw nor felt anything unusual. Although the patient stated on July 14 that she was experiencing "swelling" at the site, he did not document having examined the area, because his examination was unremarkable.

EXPERT OPINIONS

41. A lumbar CSF leak after neurological surgery is a common surgical complication, which often occurs without negligence. Its chief presenting symptom usually is a postural headache. In addition, although some CSF leaks can penetrate the skin (usually through poorly healed surgical incisions), subcutaneous CSF leaks that do not penetrate the skin sometimes cause visible or palpable swelling.

42. Respondent, Dr. Dembner, and Dr. Shuer agreed that the most serious risk from a CSF leak is meningitis, because CSF that penetrates the skin can conduct infectious organisms from outside the body into the dural space. Even CSF leaks that do not penetrate the skin can cause debilitating headaches, however, and can irritate nearby nerves. Although some CSF leaks require surgical repair, others resolve without surgery, and still others continue for months or years with no impact on the patient's long-term health.

43. Dr. Dembner testified that the standard of care requires a neurological surgeon to suspect a CSF leak in any patient who "presents with headaches, postural or not, following spine surgery." If headaches are debilitating, or persistent, the standard of care is to investigate whether CSF leak is the cause, and if so to treat the

leak with strict bedrest, compression garments, drainage, or further surgery. As to this standard, Dr. Shuer's testimony was similar.

44. Dr. Dembner believes that the patient described symptoms between February and July 2017 that should have led respondent to suspect a CSF leak. In testimony, he emphasized his belief that her symptoms were significant and debilitating, pointing to the patient's statements in April 2017 that her headaches were causing daily distress and limiting her ability to walk for exercise, and her statement in July 2017 that she had discontinued physical therapy because of "continued swelling at the incision site" and "severe pain." Dr. Dembner believes further that respondent committed an extreme departure from the standard of care by allowing these symptoms to continue for five months after surgery without taking any steps to diagnose or treat them.

45. Although the later treatment described above in Finding 38 was not fully successful in alleviating the patient's headaches, Dr. Dembner did not opine that respondent's delay in responding to the patient's CSF leak symptoms made that treatment less successful than it would have been if it had occurred more promptly.

46. Dr. Shuer believes that although the patient's self-described symptoms between February and July 2017 were consistent with the possibility of a CSF leak, they were not serious enough to warrant any action by respondent. In his view, because the patient described "non-postural and non-debilitating headache, as well as an absence of any leakage from the wound," respondent's decision to continue observing the patient without performing any other diagnostic or treatment actions was within the standard of care.

47. Dr. Dembner also believes that the standard of care for medical record-keeping requires physicians to document both positive and negative relevant observations. Because the patient had complained consistently after February 2017 of symptoms consistent with the possibility of a CSF leak, specifically in July 2017 including swelling at her incision site after activity, Dr. Dembner believes that the incision's objective condition—even if unremarkable—would have been highly relevant to respondent's clinical decision-making. He characterizes respondent's failure to document any such examination in May or July 2017 as a simple departure from the standard of care.

48. Dr. Shuer's written report states that physicians "tend to chart positive findings." In testimony, he acknowledged that the standard of care for medical record-keeping also requires a physician to document "pertinent negatives." With respect to the patient's surgical incision at her May and July 2017 office visits, however, Dr. Shuer did not consider its healed, non-swollen condition to be such a "pertinent negative."

ANALYSIS

49. In light of the matters stated in Findings 20 and 41 through 43, respondent's initial response to the patient's complaint regarding a post-surgical headache was reasonable. In light of the matters stated in Findings 20, 32 through 38, and 41 through 44, however, his failure over the next five months to recommend a trial of strict bedrest, or to order imaging to evaluate the potential CSF leak, was not.

50. Dr. Shuer's opinion, as summarized in Finding 45, that respondent acted prudently by doing nothing to investigate or address the patient's post-surgical headaches, is not persuasive. Dr. Dembner's contrary opinion, as summarized in

Finding 44, that respondent committed an extreme departure from the standard of care by allowing the patient to continue with CSF leak symptoms without even making a plan to address those symptoms specifically in the future, is persuasive.

51. In light of the matters stated in Findings 35, 37, and 40, Dr. Shuer's opinion that respondent had no duty to document the condition of the patient's surgical incision in May 2017 and July 2017 also is not persuasive. Rather, respondent's testimony (summarized in Finding 40) that the incision looked fully healed on both May 31 and July 14, and that he felt no fluid accumulation on July 14, describes highly pertinent negative observations. Dr. Dembner's opinion that respondent should have documented these observations, and that his failure to do so was a simple departure from the standard of care, is persuasive.[1]

Text Messaging

52. Around the time of the patient's first surgery in July 2016, respondent gave the patient his personal telephone number. He testified, credibly in light of all evidence, that she was very anxious about her condition and about the possible consequences of surgery, and that he wanted to reassure her that he would answer her questions and concerns.

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[1] Similarly, given the importance of postural headache in diagnosing CSF leak, respondent's failure to document clearly whether the patient's headaches resolved when she lay down is also a failure to document a pertinent observation. The first amended accusation does not allege this failure as cause for discipline, however.

53. The patient and respondent exchanged text messages episodically between September 2016 and February 2017. The patient initiated most or all of these exchanges, with questions pertaining to her condition and care.

54. Respondent used a casual tone in corresponding with the patient. For example, in corresponding with the patient after an office visit in which she had described several non-medical problems that she related to her ongoing back and leg pain, respondent said "You need to be thinking bigger [than a gift of coffee] if you're gonna drop that kinda life shit on me. Probably will require alcohol." Later that same day, as their text conversation continued on the topic of the patient's former lower-body strength-training regimen, respondent assured the patient, "Quit worrying about your ass. We'll get it back." Another day, in response to the patient's observation that he was not his "fiery self today," respondent sent the patient an x-ray image of a different patient's skull and cervical spine, explaining that he just had finished performing emergency spinal surgery on someone who probably would never walk again.

55. Respondent and the patient had not had any relationship before she became respondent's patient. They never had any social relationship other than their physician-patient relationship. No evidence suggested that either of them ever wished or attempted to pursue any social relationship, or that the patient experienced any confusion or stress because of respondent's casual tone.

56. Dr. Shuer testified that he viewed the text messages between respondent and the patient as "playful" in tone, but not unprofessional. This testimony is not persuasive.

57. Dr. Dembner did not believe that respondent had acted unprofessionally by inviting the patient to send him text messages, or by reassuring her about her prognosis for resuming exercise she formerly had enjoyed. He testified, however, that he viewed the text messages between respondent and the patient as unprofessional, and as a simple departure from the standard of care, because of their casual, personal tone, as well as their use of profanity. This opinion is persuasive.

Additional Evidence

58. Licensed vocational nurse Deanna del Junco testified about her interactions with the patient while del Junco worked in respondent's medical practice. She performed some post-operative physical examinations of the patient, and assisted respondent in other office visits. Del Junco recalls examining the patient's surgical incision herself, and seeing respondent do so after the patient's February 2017 surgery. The incision healed normally, and its condition after healing remained normal.

59. Respondent recalls having met Dr. Dembner once, in 2012, when respondent was a faculty member for a surgical-technique course that Dr. Dembner attended. He recalls Dr. Dembner specifically, because they attended a dinner together at which respondent disapproved of Dr. Dembner's behavior. Dr. Dembner testified credibly that he does not recall meeting respondent at the course or the dinner.

60. In 2016, one of respondent's business partners left their medical practice to become the medical director of neurosurgery at NorthBay Medical Center in Fairfield. She replaced Dr. Dembner in this role. Dr. Dembner testified that NorthBay Medical Center hired respondent's former partner because Dr. Dembner had decided to leave the position, and that he did not know who his replacement's medical business partners had been before his replacement joined NorthBay Medical Center.

61. Respondent raised the interactions described in Findings 59 and 60 in an effort to show Dr. Dembner's acquaintance with, and bias against, him. The evidence about these matters (as well as Dr. Shuer's testimony about having supervised Dr. Dembner in residency) establishes that Dr. Dembner has not prioritized cultivating strong, positive social relationships with other neurosurgeons during his career. The evidence did not establish Dr. Dembner's bias against respondent, however.

References

62. Jeffrey B. Randall, M.D., respondent's business partner since 2005, provided a reference letter for respondent. Dr. Randall describes respondent as "cautious," with "excellent technical skills in the operating room." He values respondent as a colleague and would entrust himself or his family to respondent's care.

63. Mark Musco, M.D., is a family physician who refers patients regularly to respondent. Dr. Musco also provided a reference letter. He has observed that respondent has good surgical judgment and skill, and that respondent's "aftercare is always complete and excellent." Dr. Musco expects to continue referring patients to respondent.

64. Michael Temkin, D.O., also is a local primary care physician who not only refers patients to respondent but also has been respondent's patient. Dr. Temkin provided a reference letter stating that he and patients he has referred appreciate respondent's "down to earth demeanor." Dr. Temkin also reports having observed "excellent" patient outcomes, without "unusual complications," from respondent's care.

65. A former patient, Tom Prescott, provided a reference letter describing four surgeries respondent performed for Prescott. Prescott was "pleased with the

results and his professionalism each time." Prescott has referred friends to respondent, and would see respondent again if appropriate.

66. Another patient, Liz Cumby, provided a reference letter describing her treatment with respondent over about ten years. Cumby appreciates respondent's conservative treatment approach. She found him "calm, supportive, and educational," and believes he achieved an excellent surgical outcome for her.

LEGAL CONCLUSIONS

1. The Board may discipline respondent's physician's and surgeon's certificate only upon clear and convincing proof, to a reasonable certainty, of the facts establishing cause for discipline. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The factual findings above rest on clear and convincing evidence.

2. Grossly negligent acts by a physician, which are acts involving extreme departures from the professional standard of care, are unprofessional conduct. (Bus. & Prof. Code, § 2234, subd. (b).)

3. Repeated negligent acts by a physician, which are acts involving simple departures from the professional standard of care, are unprofessional conduct. (Bus. & Prof. Code, § 2234, subd. (c).)

4. Acts demonstrating a physician's incompetence are unprofessional conduct. (Bus. & Prof. Code, § 2234, subd. (d).)

5. A physician's failure to maintain adequate and accurate patient care records is unprofessional conduct. (Bus. & Prof. Code, § 2266.)

First Cause for Discipline (Post-Surgical CSF Leak)

6. The matters stated in Findings 33 through 37, 49, and 50 constitute cause for discipline against respondent, for his gross negligence in delaying investigation and treatment of the patient's CSF leak symptoms following her February 2017 surgery. In light of the matters stated in Findings 5 through 8, 41, and 42, the matters stated in Findings 33 through 37, 49, and 50 do not constitute cause to discipline respondent for incompetence.

7. The matters stated in Findings 35, 37, and 51 constitute cause for discipline against respondent, for his failure to document examination of the patient's surgical scar in May and July 2017. This failure is negligent, and it renders respondent's records less than fully adequate and accurate.

Second Cause for Discipline (Text Messages)

8. The matters stated in Findings 53 through 57 constitute cause for discipline against respondent, for his repeated negligence in exchanging casual, unprofessional text messages with his patient.

Third Cause for Discipline (Incomplete Surgery)

9. The matters stated in Findings 12 through 17, 19, 20, 22 through 24, and 28 through 30 constitute cause for discipline against respondent, for gross negligence in planning, performing, and documenting the patient's July 2016 surgery in light of her May 2016 MRI. The matters stated in Findings 12 through 17, 19, 20, 22 through 24 do not constitute cause to discipline respondent for incompetence.

Disciplinary Considerations

10. As summarized in Findings 7 and 62 through 66, respondent enjoys great respect among physicians and patients. By all accounts, his errors in treating the patient were unusual, and are not representative of his typical practice.

11. The matters stated in Findings 34 and 36 mitigate somewhat respondent's unprofessional conduct with respect to the patient's CSF leak. Although respondent did not take the patient's symptoms as seriously as he should have, he did refer her to a pain specialist in April 2017 to address her post-surgical pain. That practitioner also did not take steps at that time to investigate whether the patient had a CSF leak.

12. The matters stated in Findings 24, 45, and 55 do not establish that the patient suffered permanent harm because of respondent's actions, but the patient suffered treatment delay and associated anxiety, and faced an unnecessarily heightened risk of permanent harm. Furthermore, rather than acknowledging his oversights, respondent offered *post hoc* explanations for his decisions (such as those summarized in Finding 17) that were unpersuasive, and that in any event would, if true, have implied that his medical records were even less adequate and accurate than they were. Remedial training regarding medical record-keeping and professionalism is appropriate to improve respondent's practice.

13. Protection of the public and rehabilitation, not punishment, are the purposes for which the Board exercises its disciplinary authority. (Bus. & Prof. Code, § 2229). The matters stated in Findings 6 through 8 and 62 show that respondent currently practices in a setting where he receives support and supervision, and that he is a strongly contributing member of Northern California's neurosurgical community.

Beyond the courses described in Legal Conclusion 12, a period of probation would not be likely to improve respondent's practice further. A public reprimand, with education requirements, is appropriate in this case.

ORDER

Respondent Ronnie Isaac Mimran, M.D., Physician's and Surgeon's Certificate No. A 90574, is hereby reprimanded within the meaning of Business and Professions Code section 2227, subdivision (a)(4). Respondent also must complete the following educational courses, and failure to do so in accordance with this order may be cause for further disciplinary action.

1. Medical Record Keeping Course

Within 60 calendar days of the effective date of this decision, respondent shall enroll in a medical record keeping course 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 months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one 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 first amended 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 certification of successful completion of the medical record keeping course 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 this 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 California Code of Regulations, title 16, 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 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 year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the first amended 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 certification of successful completion of the professionalism program 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.

DATE: 12/31/2021

Juliet E. Cox

JULIET E. COX

Administrative Law Judge

Office of Administrative Hearings

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

In the Matter of the First Amended Accusation Against: **RONNIE ISAAC MIMRAN, M.D.** 1320 El Capitan Dr., Suite 300 Danville, CA 94526 Physician's and Surgeon's Certificate No. A 90574, Respondent.	Case No. 800-2018-046464 **FIRST AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On March 23, 2005, the Medical Board issued Physician's and Surgeon's Certificate Number A 90574 to Ronnie Isaac Mimran, 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 November 30, 2022, unless renewed.

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JURISDICTION

3. This First Amended 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 provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states, in pertinent part, that the Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes, but is not limited to:

(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.

(d) Incompetence

6. Section 2266 of the Code provides that 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/Repeated Negligent Acts/Incompetence/Inaccurate and Inadequate Medical Records)

7. Respondent is a neurosurgeon who specializes in spine surgery. Respondent first saw Patient 1 in March 2014 for a complaint of back pain persisting for a year. Respondent reviewed the patient's past treatment and an MRI report. He recommended a surgical procedure, and the patient agreed to return when she was ready to proceed with lumbar surgery. Patient 1 reported some improvement in symptoms at a June 2014 follow-up visit. Respondent recommended

conservative therapy, and again, noted the patient would call when she was ready to proceed with surgery.

8. Patient 1 had several visits with Respondent in 2016 due to worsening pain. A May 2016 MRI revealed, among other issues, degenerative disc disease at the L4-5 level, with bilateral foramina disease and disc herniation. Patient 1 elected to undergo surgery. On July 26, 2016, Respondent performed a L4-5 transforaminal interbody fusion. After some initial improvement, Patient 1 again reported back and nerve pain, and a painful hard spot near the incision. A December 22, 2016 MRI of the lumbar spine showed an area that might represent a sequestered disc[1] or a schwannoma.[2] Respondent recommended additional surgery.

9. Respondent performed a second surgery on February 23, 2017. The procedure was described as L-4-L5 extraforaminal decompression of the right L5 nerve root, exploration of previous spinal fusion L4-L5, and removal and replacement of L4-L5 and stabilization hardware, pedicle screws and rod. The operative report noted removal of what appeared to be a calcified disc herniation in the region of the axilla of the nerve root, which had worn through some of the dura[3] and created a "very thin spot." No leakage of cerebrospinal fluid (CSF) was noted. Because of the thin area of dura, a small patch of the graft material Duragen was placed and the area was sealed with DuraSeal as a precautionary move.

10. Within days of the second surgery, Patient 1 reported a "severe headache and bad nerve pain in right leg." Respondent informed the patient that there might be a "little spinal fluid leak" and advised her to lie down and the headache should resolve.

11. Patient 1 was seen post-operatively on March 7, 2017. She reported severe right calf and ankle pain, and informed Respondent she still had headaches. Patient 1 states that Respondent informed her he had repaired a small tear during the surgery, and that she would improve with time. Respondent's record noted the Patient's headache had improved, and indicated a possible CSF leak. He recommended continued bedrest. Notes of visits on April 7,

[1] A sequestered disc is a term used to describe a particular type of ruptured disc, when a piece of disc breaks away from the disc structure.

[2] A schwannoma is a type of nerve tumor. Schwannomas are generally benign, but can put pressure on the nerves around them.

[3] The dura is a membrane covering the spinal cord.

2017 and May 31, 2017 reference ongoing daily headache. Patient 1 states she also informed Respondent that her legs "felt like they were on fire." Respondent's May 31, 2017 progress note does not document an examination of the surgical wound. Patient 1's final visit with Respondent was on July 14, 2017. She informed Respondent that she had to discontinue physical therapy because of swelling at the incision and severe pain, conditions she felt were worsening over time. She reported ongoing headaches. Respondent did not document any examination of the wound site, although Patient 1 states that for the first time since the surgery, he looked at her back and told her it looked fine. Respondent's plan was to discontinue physical therapy, return the patient to pain management and consider a spinal cord stimulator. No plan for assessment of Patient 1's headache was noted.

12. In August 2017, Patient 1 began care with a different neurologist recommended by her primary care physician. The new neurologist suspected a CSF leak and ordered an MRI. The MRI revealed a significant fluid collection consistent with a dural tear with CSF leak. In November 2017, Patient 1 was seen at University of California San Francisco complaining of back pain, leg pain and severe headache. Studies revealed a large pseudomeningocoele[4] tracking the dura at L5-S1. On January 5, 2018, the pseudomeningocoele was aspirated.

13. On January 12, 2018, Patient was admitted to the hospital for worsening headache and vertigo. The pseudomeningocoele was again demonstrated on MRI. Surgery was performed, and an area of absent dura was identified. It could not be sewn closed, and a repair was attempted using a piece of muscle and fibrin glue. Patient 1 continued to experience headache and pain.

14. Respondent was interviewed by the Medical Board's investigator and medical consultant on June 25, 2020. Respondent acknowledged Patient 1's complaint of headache, but described the headaches as never "too big of an issue." He indicated that he recommended bedrest to treat the headache, and counseled Patient 1 they would manage the headache as "best we can." Respondent noted Patient 1 was "very convinced" the headaches were the result of a CSF leak, but that in his view, there were many possible explanations for the headaches. Respondent felt that if there was a leak, it was small and contained. Respondent stated that as

[4] A pseudomeningocele is a collection of CSF fluid.

long as a CSF leak is contained, and not leaking from the skin, it is self-limited and does not require repair or exploration. Although he was ultimately convinced a leak was the source of Patient 1's headaches, he considered it contained and therefore, in his view, there was no indication for further procedures.

15. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject to discipline pursuant to Sections 2234 and/or 2234(b) and/or 2234(c) and/or 2234(d), and/or 2266 of the Code based upon gross negligence and/or repeated negligent acts and/or incompetence, and/or failure to maintain accurate and adequate records, including but not limited to the following:

A. Respondent failed to take the steps necessary to assess or address Patient 1's ongoing complaint of headache and pain, even after he concluded that she most likely had a cerebrospinal fluid leak.

B. Respondent failed to diagnose and treat a post-operative cerebrospinal fluid leak.

C. Respondent lacked the requisite knowledge and ability to appropriately treat Patient 1's post-operative headache, to correctly diagnose a CSF leak, and was unaware of the need to treat a persistent, symptomatic CSF leak.

D. Respondent failed to document any examination of Patient 1's surgical wound when presented with symptoms concerning for a post-operative CSF leak.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

16. Early in his treatment of Patient 1, Respondent provided her with his personal cell phone number so that she could communicate directly with him regarding her concerns. Respondent and Patient 1 had a series of text messages, mostly centered around her medical treatment and condition. However, some of the text messages between Respondent and Patient 1 took on an informal, personal and flirtatious tone more consistent with a familiar conversation between friends than between a physician and patient. On one occasion, Respondent sent Patient 1 a picture of an imaging study of a different patient Respondent had treated.

17. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject to discipline pursuant to Section 2234 of the Code in that he failed to maintain a professional demeanor and manner with his patient.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts/Incompetence and Inadequate Medical Records)

18. Paragraphs 1 through 17 are incorporated as set forth herein.

19. One of the findings from Patient 1's May 2016 MRI radiology report was a right paracentral disc-sequestration at the L4-5 level that was touching and displacing the right L5 nerve root. The May 2016 MRI imaging shows a disc fragment sitting at the L4-5 level.

20. Patient 1 had a follow- up visit with Respondent on June 13, 2016. Before Patient 1's surgery on July 26, 2016, Respondent had available to him the May 2016 MRI of the lumbar spine. Despite the May 2016 MRI imaging identifying a disc fragment at the L4-5 level, and despite the radiology report from the same MRI identifying a L4-5 disc-sequestration displacing the right L5 nerve, Respondent did not mention to Patient 1 this disc-sequestration pathology or discuss a plan for addressing it, nor did he document an assessment of the MRI findings regarding the disc-sequestration touching and displacing the L5 nerve root.

21. Patient 1 underwent surgery on July 26, 2016. Respondent describes performing a bilateral L4-5 transforaminal interbody instrumentation and fusion with bilateral pedicle screw instrumentation. Respondent did not describe exploring the course of the L5 nerve root during the surgery. Nor did he describe identifying the sequestered disc fragment during the surgery. However, the disc fragment was well demonstrated in the images from the O-arm intraoperative CT scan of the lumber spine taken before placement of the hardware.

22. After the July 2016 surgery, Patient 1 continued to experience pain. Patient 1 underwent further MRI imaging in December 2016. The radiology report for Patient 1's December 2016 MRI of the lumbar spine used Patient 1's May 2016 MRI as a comparison study. The December 2016 MRI report found that there was still asymmetry at the right L5 nerve which was unchanged. That radiology report also noted that this was previously thought to have been an

extruded disc fragment or sequestered disc. The impression from the radiology report was that the persistent asymmetry of the right L5 nerve at the L4-5 level could be a sequestered disc or a schwannoma.

23. After the December 2016 MRI, Respondent had a follow-up telephonic consultation with Patient 1 to discuss the results. Respondent's impression at this encounter was that Patient 1 had a possible disc or schwannoma at the right L5 nerve root, and gave Patient 1 the option of surgery. All surgeries are associated with inherent risks, and the risk of CSF leak is greater during re-operations in the spine when scar tissue adjacent to the thecal sac must be resected and/or dissected through.

24. Patient 1 underwent the second surgery with Respondent on February 23, 2017, nearly seven months after her first surgery. During that surgery, Respondent described the need to resect a portion of the right L5 lamina to identify the disc fragment under the superior edge of the L5 lamina. The operative report noted removal of what appeared to be a calcified disc herniation in the region of the axilla of the nerve root. It had worn through some of the dura and created a very thin spot. Several large fragments of disc combined with bone were removed, along with pressure from the nerve root.

25. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject to discipline pursuant to Sections 2234 and/or 2234(b) and/or 2234(c) and/or 2234(d) and/or 2266 of the Code based upon gross negligence and/or repeated negligent acts and/or incompetence, including but not limited to the following:

A. Respondent failed to identify and address the disc-sequestration demonstrated before the first surgery in July 2016, resulting in the need for re-operation, exposed Patient 1 to a period of additional symptomatology and all of the inherent and increased risks of a second surgery.

B. After obtaining the MRI imaging and radiology report from the May 27, 2016 MRI, Respondent failed to mention at the next pre-operative encounter with Patient 1 the finding of disc-sequestration displacing the right L5 nerve.

C. At the July 26, 2016 surgery, Respondent failed to utilize the information available to him from the May 27, 2016 MRI demonstrating the disc-sequestration finding and the need to

address it at surgery with resection of the L5 lamina and exploration of the course of the L5 nerve root beyond what would be necessarily required during a routine L4-5 trans-foraminal interbody instrumentation and fusion surgery. As a result, the disc fragment was not removed at the July 26, 2016 surgery, leaving Patient 1 with an untreated, symptomatic condition that was not finally addressed until the subsequent surgery nearly seven months later on February 23, 2017.

D. Respondent failed to address the disc-sequestration pathology at the July 26, 2016 surgery, and accordingly unnecessarily exposed Patient 1 to risk when the pathology was not addressed until the second surgery on February 23, 2017, as all surgeries are associated with inherent risks, and the risk CSF leak is greater during re-operations in the spine when scar tissue adjacent to the thecal sac must be resected and/or dissected through.

E. Respondent failed to document an assessment of the May 2016 MRI findings regarding the disc-sequestration touching and displacing the L5 nerve root.

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 90574, issued to Ronnie Isaac Mimran, M.D.;

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

3. Ordering Ronnie Isaac Mimran, 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: JUN 0 8 2021

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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