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

In the Matter of the First Amended Accusation Against: **Zane Aaron Shaeffer, M.D.** Physician's and Surgeon's Certificate No. A 135109 Respondent.	Case No: 800-2019-056976

ORDER CORRECTING NUNC PRO TUNC CLERICAL ERROR IN "CERTIFICATE NO." PORTION IN THE ORDER

On its own motion, the Medical Board of California (hereafter "Board") finds that there is an error in the Certificate No. in the Order section on page 26 of the Decision in the above-entitled matter and that such clerical error should be corrected so that the Certificate No. will conform to the Board's issued license.

IT IS HEREBY ORDERED that the Decision in the above-entitled matter be and hereby is amended and corrected nunc pro tunc as of the date of entry of the Order to reflect that the Certificate No. in the Order is A 135109.

September 13, 2022

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 First Amended Accusation Against: Zane Aaron Shaeffer, M.D. Physician's and Surgeon's Certificate No. A 135109 Respondent.	Case No.: 800-2019-056976

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 September 29, 2022.

IT IS SO ORDERED: August 30, 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 First Amended Accusation against:

ZANE AARON SHAEFFER, M.D., Respondent

Agency Case No. 800-2019-056976

OAH No. 2021120394

PROPOSED DECISION

Erin R. Koch-Goodman, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on May 23 through 25, and 27, 2022, from Sacramento, California.

Ryan J. McEwan, Deputy Attorney General (DAG), appeared on behalf of William Prasifka (complainant), Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

Ann Larson, Attorney at Law, Law Offices of Craddick, Candland and Conti, appeared on behalf of Zane Aaron Shaeffer, M.D. (respondent), who was present at hearing.

Oral and documentary evidence was received, the record closed, and the matter submitted for decision on May 27, 2022.

FACTUAL FINDINGS

Jurisdictional Matters

1. On March 16, 2015, the Board issued Physician's and Surgeon's Certificate (license) No. A 135109 to respondent. The license is in full force and effect until September 30, 2022, unless renewed or revoked.

2. On September 17, 2021, complainant, in his official capacity, made and served an accusation on respondent seeking to discipline his license. On March 18, 2022, complainant made and served a First Amended Accusation (Accusation) on respondent. The Accusation alleges respondent violated Business and Professions Code[1] sections 2227, 2234, subdivisions (b) and (c), and 2266, when he was unprofessional in his care and treatment of Patient 1: committing gross negligence, repeated negligent acts, and failing to maintain adequate and accurate medical records. More specifically, complainant alleges, on February 20, 2019, while working in the emergency department (ED) at the Kaiser Permanente Roseville Medical Center Hospital (Kaiser Roseville), respondent failed to appreciate and treat Patient 1's extremely high blood pressure (BP), including failing to timely administer a fast-acting antihypertensive medication and/or ordering an Magnetic Resonance Imaging (MRI) or Computed Tomography (CT) study to exclude end-stage organ damage to the brain; while also failing to complete accurate and complete medical record of the encounter.

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[1] All further citations are to the Business and Professions Code unless otherwise specified.

3. On or about September 30, 2021, respondent timely filed a Notice of Defense. This hearing followed.

Patient 1

4. On February 20, 2019, at 7:07 p.m., Patient 1, a 38-year-old man, presented to the ED with a chief complaint of "hypertension: weakness and headache for 2 weeks with nausea/vomiting and lately elevated BP; last night with chest pain." Patient 1 arrived by personal vehicle with his wife and had an initial medical screening at 7:13 p.m. He had a temperature of 98.6 degrees, respiration at 16, pulse at 88, BP at 213/139 (sitting), blood oxygen saturation of 99 percent, and weight of 186 pounds. At 7:15 p.m., his BP was retaken and read 223/153 (sitting). At 7:16 p.m., Registered Nurse (RN) Neil B. Martinez recorded Patient 1's pain score as zero, and designated Patient 1 as a high fall risk, based upon his "Nursing Judgement," and placed a yellow paper band on Patient 1's wrist so other ED staff would be aware Patient 1 was unbalanced or shaky on his feet and needed assistance when standing and/or walking.

5. At 7:19 p.m., RN Martinez entered a standard electrocardiogram (EKG) order, put Patient 1 in a wheelchair and wheeled him to the surge-D waiting area. At 7:21 p.m., Patient 1 had an EKG, showing "Sinus rhythm; Nonspecific T abnormalities (lateral leads); [and] Borderline ST elevation (anterior leads)."

6. At 7:34 p.m., RN Patricia Donnelly entered a standard order for aspirin, but noted: "Not given: contraindicated, possible bleed." At 7:39 p.m., blood was taken for a complete blood count (CBC) with differential, chem 7 (blood urea nitrogen (BUN), carbon dioxide, creatinine, glucose, chloride, potassium, and sodium), alanine transaminase (ALT), bilirubin, alkaline phosphatase, lipase, troponin, and B-type natriuretic peptide (BNP).

7. At or about 7:40 p.m., respondent conducted an examination of Patient 1, including a review of Patient 1's medical record, revealing Patient 1 had a history of hypertension, obesity and hyperlipidemia. Respondent spoke to Patient 1 and his wife and then completed a physical examination. At 7:44 p.m., respondent ordered a CT of Patient 1's abdomen to "rule out diverticulitis." At 7:49 p.m., Patient 1 was sent to the restroom to provide a urine sample for testing. At 7:51 p.m., the urinalysis showed all negative results. At 7:54 p.m., a chest x-ray was performed with normal results. At 8:03 p.m., the blood tests showed normal results with the exception of a high red blood cell count of 5.77 (range 4.10 to 5.70 million per microliter (M/ul)) and hemoglobin (Hgb) of 17.7 (range 13.0 to 17.0 grams per deciliter (g/dL)).

8. At 9:59 p.m., the abdominal and pelvis CT was performed with unremarkable findings. At 10:41 p.m., Patient 1's BP was retaken and read 203/132 with a pulse of 78. At the same time, respondent ordered amlodipine (BP medication) 10 milligrams (mg.) and acetaminophen (pain medication) 1000 mg. oral; and Patient 1 was administered the same. At 11:14 p.m., Patient 1's BP was retaken and read 211/129 (lying) with a pulse of 73. At 11:21 p.m., respondent entered the discharge order for Patient 1. At 11:36 p.m., RN Maribella Ortiz reported Patient 1's elevated BP to respondent; respondent nonetheless confirmed Patient 1's discharge. Patient 1 and his wife left the ED.

9. A review of the electronic medical record (EMR) shows respondent's charting of his encounter with Patient 1 as follows:

> **Chief Complaint**: Hypertension – weakness and headache for 2 weeks with nausea/vomiting and lately elevated BP; last night with chest pain.

HPI - [Patient 1] is a 38 Y[ear old] male who presents to the [ED] with Chief complaint of generalized weakness. To 3 weeks of not feeling very well. Complains of generalized weakness. Patient has a known history of hypertension has refused to take blood pressure medications and has been noncompliant on them for some time now. Patient [1] states that his blood pressures [have] been elevated at home. The wife has been checking his blood pressure. And his blood pressure has been elevated. No fever. He does smoke daily. He has had a history of asthma he has had some nausea and vomiting.

Additional history obtained from chart review.

Social History - smokes tobacco daily.

ROS - Constitutional: Negative for fever and chills. Skin: Negative for rash. [Head, Eyes, Nose, Throat] HENT: Negative for headaches, ear pain and sore throat. Eyes: Negative for blurred vision. Cardiovascular: Negative for chest pain, palpitations and leg swelling. Respiratory: Negative for cough and shortness of breath. Is not experiencing shortness of breath or wheezing. Gastrointestinal: Negative for nausea, vomiting, abdominal pain, diarrhea and constipation. Genitourinary: Negative for dysuria and flank pain. Musculoskeletal: Negative for neck pain and falls. Neurological: Negative for dizziness and focal

weakness. Psychiatric/Behavioral: Negative for substance abuse.

Physical Exam – Vitals reviewed. Constitutional: He is oriented to person, place, and time. He appears well-developed. No distress. Vital Signs Reviewed. HENT: Head: Normocephalic and atraumatic. Right Ear: External ear normal. Left Ear: External ear normal. Nose: No nasal deformity. Mouth/Throat: Oropharynx is clear and moist. No oropharyngeal exudate. Eyes: Pupils are equal, round, and reactive to light. Conjunctivae are normal. Right eye exhibits no discharge. Left eye exhibits no discharge. No scleral icterus. Neck: Normal range of motion. Neck supple. No [jugular vein distention] JVD present. No tracheal deviation present. No thyromegaly (visible) present. Cardiovascular: Normal rate, regular rhythm and normal heart sounds. [Point of maximum impulse] PMI is not displaced. Exam reveals no gallop and no friction rub. No murmur heard. Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress. He has no wheezes. He has no rales. He exhibits no tenderness. Abdominal: Soft. He exhibits no distension and no mass. There is no splenomegaly or hepatomegaly. There is no tenderness. There is no rebound and no guarding. Lymphadenopathy: He has no cervical adenopathy. Neurological: He is alert and oriented to person, place, and time. He displays normal reflexes. No cranial nerve deficit. He exhibits normal muscle

tone. Coordination normal. Skin: Skin is warm and dry. No rash noted. No cyanosis or erythema. No pallor. Nails show no clubbing. Psychiatric: He has a normal mood and affect. Judgment normal.

Initial Impression/Medical Decision Making – Patient with weakness, headache. Work up: Screening labs Treatment: IV, Monitor.

ED Course – [Differential Diagnosis] DDx: Tension headache, Migraine, Sinusitis, [subarachnoid hemorrhage] SAH, [intracerebral hemorrhage] ICH, Trauma, Meningitis. Troponin normal. White Blood cell count normal. His hemoglobin is high at 17.7, no obvious signs of [deep vein thrombosis] DVT or clot. His urinalysis was done which shows no hemoglobin [blood] in his urine. Patient has hypertension here in the [ED]. Amlodipine home dose given. Patient will be sent home with 10 mg. of amlodipine.

Diagnostic Studies /Data Review – Labs: Reviewed and interpreted by me.

Assessment and Plan - Hypertension-start to take amlodipine 10 mg. Weakness-possibly related to hypertension. Patient also appears depressed. His wife states he is depressed due to work and family.

Final Diagnosis - Hypertension Weakness.

Disposition - Home.

Condition on Disposition - stable.

Consumer Complaint

10. On or about June 24, 2019, the Board received a complaint from Patient 1's wife, alleging respondent failed to provide adequate care to Patient 1 on February 20, 2019, in the Kaiser Roseville ED. The Board assigned the complaint to Inspector Lindsay Brearly for examination and review. Inspector Brearly interviewed Patient 1's wife and respondent and obtained Patient 1's medical records for February 20, 2019.

11. Patient 1's wife testified at hearing. She filed a complaint with Kaiser and the Board because she was disappointed with the care and treatment Patient 1 received from respondent. On February 20, 2019, Patient 1's wife took Patient 1 to the ED, because he had come home from work early three days in a row, had immediately gone to bed, and complained of a headache, nausea, and vomiting. At the ED, Patient 1's wife described Patient 1 as sleepy, resting with his eyes closed, and difficult to arouse; confused; not speaking and only nodding or shaking his head to answer questions, moaning and pointing to his head when asked about pain; and was off-balance and needed help to stand or walk. She was surprised when respondent did not give Patient 1 medication to lower his BP. In addition, she had assumed respondent ordered a brain CT, and not abdominal CT, when respondent reported unremarkable findings. Finally, at discharge, respondent told Patient 1 to continue his BP medication until his visit with his primary care physician (PCP) and be prepared for a worse headache as the BP medication took effect, suggesting worsening headache

symptoms were nothing to be concerned about. However, after three days, Patient 1's wife took Patient 1 back to the Kaiser Roseville ED for further care and treatment.

Medical Evidence

BOARD EXPERT – SERINEH MELIDONIAN, M.D., EMERGENCY MEDICINE

12. Dr. Melidonian completed her Bachelor of Science in Health Promotions and Disease Prevention Studies, with a minor in Bioethics, at the University of Southern California (USC) in 1999, before completing her Medical Doctorate at Tufts University School of Medicine, in Boston in 2003. Dr. Melidonian then completed a one-year internship in internal medicine at the University of California, San Francisco (Fresno location) and a three-year residency in emergency medicine at the USC, Keck School of Medicine, Los Angeles Medical Center. In 2004, she became licensed to practice medicine in California. She is Board-Certified by the American Board of Emergency Medicine (ABEM). Since July 2007, Dr. Melidonian has practiced as an ED staff physician in three hospitals: fulltime, parttime, and per diem. Currently, she works fulltime at Glendale Medical Center, an Adventist Health facility, where she has been a member of several administrative committees, including providing opinions on physician and midlevel patient care and providing executive oversight to the hospital. She has acted as a Board Expert Medical Examiner since 2017, reviewing approximately 12 cases, and testifying for the first time in this matter.

13. The Board retained Dr. Melidonian to conduct a review of documents and provide an opinion on whether respondent acted within the standard of care when he treated Patient 1. The Board provided Dr. Melidonian with the following documents: the consumer complaint, certified medical records for Patient 1 from Kaiser Roseville, respondent's summary of care, respondent's curriculum vitae, and the recording and

transcript of respondent's Board interview. Dr. Melidonian reviewed the documents and wrote a report, dated June 3, 2021, finding respondent committed one extreme departure and one simple departure from the standard of care when treating Patient 1. More specifically, Dr. Melidonian found respondent committed an extreme departure when "[respondent] did not get the necessary studies to exclude subarachnoid hemorrhage [SAH], intracranial hemorrhage [ICH] or hypertensive encephalopathy" and failed to provide "sufficient treatment with adequate [BP] regulation and inpatient monitoring." Dr. Melidonian also found respondent committed a simple departure when he documented inaccuracies in the medical record in the ROS and past history; and he provided insufficient documentation regarding the "neurological exam, without specific mention of gait" and the "medical decision making to address the vague neurological complaints of headache, nausea, vomiting and lethargy, and specifically what led [respondent] to exclude the diagnoses of [SAH] or [ICH]." Dr. Melidonian testified at hearing consistent with her report.

14. At hearing, Dr. Melidonian noted that ED physicians see patients with high BP on every shift: Patient 1 was an example. He presented to the ED with uncontrolled hypertension, recording a BP greater than 180/110, neurological symptoms of headache, nausea, vomiting and lethargy/weakness for two weeks, and a cardiological symptom of chest pains the previous night. When a patient presents to the ED with uncontrolled hypertension, the ED physician must first look for any signs of end-organ damage. In this case, Patient 1 reported neurological (brain) and cardiological (heart) symptoms, along with a markedly elevated BP. As such, the standard of care required respondent to assess and rule out end-organ damage to the brain, heart, kidneys, and eyes. While respondent ordered testing for the heart and kidneys, he failed to order testing of the brain. While respondent identified several possible brain diagnoses in his DDx, including migraine, tension headache, SAH and

ICH, he failed to order an MRI or CT scan of the brain and/or order a fast-acting BP medication to lower Patient 1's BP in an attempt to eliminate the neurological complaints (headache, nausea, vomiting, weakness, and lethargy). According to Dr. Melidonian, respondent could have done either or both and meet the standard of care, but he did neither. Given all of the above, Dr. Melidonian concluded, respondent failed to provide adequate care and treatment to Patient 1 and his failure constituted an extreme departure from the standard of care.

15. Dr. Melidonian also found respondent's charting to be inaccurate and insufficient and a simple departure from the standard of care. According to Dr. Melidonian, respondent failed to correctly document Patient 1's symptoms in the HPI, ROS and physical examination.[2] In the HPI, respondent made no reference to Patient 1's complaints of headache, nausea, vomiting, lethargy, or chest pains. In the ROS, respondent charted all negative findings when the HENT (headache), cardiovascular (chest pain), gastrointestinal (abdominal pain, nausea and vomiting), neurological (headache, nausea, vomiting, weakness), and psychiatric/behavioral (depressed) should have been listed as positive. Respondent also documented a normal physical examination, noting in the neurological examination: "[Patient 1] is alert and oriented to person, place, and time. He displays normal reflexes. No cranial nerve deficit. He exhibits normal muscle tone. Coordination normal." However, respondent failed to document Patient 1's gait or ability to walk as a part of his neurological examination, which is inconsistent with RN Donnelly identifying Patient 1

[2] Dr. Melidonian also found respondent failed to update Patient 1's past and social history related to smoking, but the evidence proved respondent was unable to make changes to those sections of the EMR from the ED.

as a fall risk, and Patient 1's wife describing Patient 1 unsteady. In addition, Patient 1's wife described Patient 1 as the opposite of alert and oriented; he was sleepy, difficult to arouse, confused, not speaking, moaning and pointing to his head, off-balance and needed help to stand or walk. Finally, Dr. Melidonian found fault with respondent's charting because he failed to chart his medical decision-making, including his interpretation of imaging studies and explanations for any abnormal findings. For example, the chart should have included documentation such as: EKG abnormal uncontrolled hypertension; rationale for abdominal CT, more detail needed than "rule out diverticulitis" written in order; symptoms charted to support an abdominal CT, especially with normal white blood cell count; and rationale to exclude brain CT when SAH and ICH were in the DDx.

RESPONDENT'S EXPERT – ERIC ROY SNOEY, M.D., EMERGENCY MEDICINE

16. Dr. Snoey completed his Bachelor of Science in Biomedical Sciences in 1981 before completing his Medical Doctorate in 1985, both from the University of Michigan. Dr. Snoey then completed a one-year internship in transitional medicine and a two-year residency in emergency medicine at the University of California, Los Angeles, Harbor Medical Center. In 1986, he became licensed to practice medicine in California. He is a Board-Certified by ABEM and a Diplomate of the American College of Emergency Physicians (ACEP). Since April 1987, Dr. Snoey has practiced as an ED staff physician in eight hospital settings. Since 1990, he has also held teaching positions including ED faculty at Highland Hospital (Alameda Health System), and since 2005, as clinical professor at the University of California, San Francisco Medical Center. Currently, Dr. Snoey is the ED Vice Chair at Highland Hospital. Dr. Snoey has held administrative positions, participated in international medical missions to Mexico and Russia, and has published articles, case reports, and book chapters and given

presentations on emergency medicine. He has provided opinions and testified in medical malpractice matters.

17. Respondent retained Dr. Snoey to conduct a review of documents and provide an opinion on whether respondent acted within the medical standard of care when he treated Patient 1. Respondent provided Dr. Snoey with the following documents: the Accusation, Dr. Melidonian's Report, the Board's Investigative Report and Supplemental Report and attachments including consumer complaint, respondent's summary of care, transcript of Board interview with respondent, and certified medical records for Patient 1 from Kaiser Roseville. Dr. Snoey reviewed the documents and wrote a report, dated March 25, 2022, finding respondent acted within the standard of care when treating Patient 1 and charting the encounter. Dr. Snoey testified consistent with his report.

18. At hearing, Dr. Snoey noted that ED physicians see patients with hypertension on every shift: Patient 1 was an example. For Dr. Snoey, Patient 1 presented to the ED with uncontrolled hypertension and vague, non-specific complaints of "weakness and headache for 2 weeks with nausea/vomiting and lately elevated BP; last night with chest pain." Dr. Snoey dismissed Patient 1's complaints as generic, applicable to hundreds of diagnoses, and not markers of signs or symptoms of end-organ damage from uncontrolled hypertension. As such, Patient 1 had asymptomatic hypertension and the standard of care required monitoring over several hours and a referral to his PCP for ongoing BP care. For Dr. Snoey, respondent acted within the standard of care when "[he] kept the patient for work up and observation over several hours. . . . and did not note any significant changes in the patient's condition warranting additional work up. Discharge home with BP medication and

instructions to seek follow-up treatment with outpatient [PCP] was appropriate and consistent with ACEP guidelines."

19. In fact, Dr. Snoey believes respondent went beyond the standard of care in his treatment of Patient 1. Dr. Snoey opined: "[respondent] ordered more workup than the standard of care requires for a patient without symptoms of acute end organ injury, as per ACEP guidelines: patients without specific symptoms suggestive of acute end organ injury, do not need routine labs, EKG, chest x-ray, fundoscopy on examination, etc." Nonetheless, respondent ordered imaging studies and blood tests to assess and rule-out processes related to the heart, kidneys, and abdomen. In addition, Dr. Snoey found respondent's neurological examination of Patient 1 to be complete and revealed no positives, so there was no need to test or assess the brain any further. According to Dr. Snoey, "[t]he standard of care does not oblige [the] ordering of a CT of the head based on a simple combination of elevated blood pressure and nausea and vomiting, even in the setting of reported headache." In fact, "[s]ymptoms of nausea and vomiting are very non-specific and are not widely accepted as symptoms indicating a hypertensive emergency." Furthermore, Dr. Snoey noted: "[t]he standard of care, and accepted practices of the [ED], do not require a provider to work on controlling a patient's BP in the [ED] to determine whether the headache improved, [because] the relationship between BP elevation and headache is very weak." Given all the above, Dr. Snoey concluded, respondent acted within the standard of care when he treated Patient 1 in the ED on February 20, 2019.

20. In addition, Dr. Snoey found respondent's charting to be within the standard of care, even with the inaccurate ROS, "as the substantive inputted record accurately reflects [respondent's] assessment and clinical work up." According to Dr. Snoey, "[t]he standard of care does not require an emergency medicine physician

to document interpretations of studies, such as chest x-ray or EKG, when such is [*sic*] unremarkable or inconsequential to the clinical course of the patient"; nor does the standard of care require documentation that a DDx was ruled out. In addition, "a diagnosis on a differential does not obligate that each [DDx] is specifically ruled via testing. One can consider a diagnosis and then eliminate it based on clinical judgement, which was done by [respondent] here." Ultimately, Dr. Snoey concluded, respondent's documentation met the standard of care threshold, but acknowledged it was "quite thin."

RESPONDENT

21. Respondent completed an Associate of Arts in Spanish in 2001 at Brigham Young University (Idaho) before completing a Bachelor of Science in Latin American Studies and Community Health Education and a Certificate in Gerontology in 2005 and a Master of Science in Public Health in 2007 from Brigham Young University (Provo). In 2012, he earned a Medical Doctorate from St. George's University in Grenada, West Indies. Respondent then completed a three-year residency in emergency medicine at the University of Texas, Austin, Dell Medical School. In 2015, respondent was licensed to practice medicine in California. He is a Board-Certified and a Diplomate of the ABEM. Since 2015, respondent has practiced as an ED attending physician at Kaiser Roseville ED and Kaiser Sacramento Morse Avenue (Kaiser Sacramento) ED.

22. Like both experts, "[respondent] frequently evaluate[s] hypertension in the [ED]. When a patient has uncontrolled hypertension, [respondent] order[s] lab work to evaluate kidney function, electrolytes and cardiac function. I also do [an] EKG and x-ray chest. I do start those patients on oral BP control and have them follow up

with their PCP. If the patient is neurologically intact, it is not routine for me to order [a] CT head on that patient."

23. In this case, Patient 1 presented to the ED "not feeling himself for two weeks . . . [with] complaints of fatigue, headache, decreased appetite, chest pain and abdominal pain." A review of the medical record showed a history of hypertension and Patient 1 and his wife reported noncompliance with medication. Respondent completed a physical examination and then ordered his routine imaging for an uncontrolled hypertension patient, including an EKG and chest x-ray, along with blood work. He also added an abdominal CT because Patient 1 complained of abdominal pain, decreased appetite, nausea and vomiting. Because the EKG showed slightly abnormal findings, respondent ordered a troponin and BNP test to confirm positive cardiac function; and the urine to confirm positive kidney function. The blood work revealed all negatives except for a slightly elevated hemoglobin. Respondent's plan of care was to start Patient 1 on oral BP medications and schedule Patient 1 for follow-up with his PCP. At 10:41 p.m., respondent ordered Patient 1 his prescribed BP medication, amlodipine 10 mg., and Tylenol for pain, and then discharged Patient 1. Respondent also scheduled Patient 1 for an appointment with his PCP within the next 48 hours. While in the ED, Patient 1 remained stable, and no one reported a change in his mentation. Respondent believes he practiced within the standard of care when he treated Patient 1 and was not required to order a brain MRI or CT or act to lower Patient 1's BP to potentially alleviate so-called neurological complaints.

24. Finally, respondent was not concerned about neurological issues, including a stroke or encephalopathy. Traditionally, respondent reported, stroke victims arrive to the ED by ambulance, and they are not alert and not talking. Here, Patient 1 showed no signs of confusion. He was alert and oriented to person, time, and

place. Patient 1 reported a pain score of zero and did not describe his headache as an acute onset or his worst headache ever. In addition, respondent's neurological assessment of Patient 1 was negative for abnormalities: Patient 1 had intact sensation and motor function in all extremities and could walk without difficulty. Patient 1 was symmetrical, could raise eyebrows, smile, and had no pronator drift. In addition, Patient 1 stood up and took several steps, had no focal deficits, and no vision changes. Therefore, "[c]ranial nerves were all intact." Moreover, "[Patient 1] had been going to work and keeping up with his daily and family responsibilities." Nonetheless, respondent's discharge instructions included "precautions to the patient and spouse that if [the amlodipine] did not bring down his BP over time that he would need to return [to the ED]."

25. Respondent admitted charting his encounter with Patient 1 using templates in the EMR. He adopted many of the EMR auto-populated options. More specifically, respondent acknowledged his ROS was inaccurate, because it did not reflect the positives reported by Patient 1 for HENT, cardiovascular, gastrointestinal, and neurological, and respondent's psychiatric/behavioral determination. Respondent also admitted to not listing Patient 1's abdominal pain in the record anywhere. In addition, he conceded not making a complete and/or thorough DDx list in the chart; instead, his practice is to enter only the generalized area (i.e., headache) and allow the EMR to insert related diagnoses (i.e., "tension headache, migraine, sinusitis, SAH, ICH . . ."). Furthermore, respondent does not chart when each diagnosis is ruled out of the differential; however, he does make a specific final diagnosis (here, hypertension and weakness). Finally, respondent does not chart unremarkable imaging results, especially if the imaging is uploaded to the EMR. Respondent believes his charting is sufficient for the ED and is within the standard of care.

Character Evidence

26. Respondent offered two letters of support from Drs. Vinh Lee, Kaiser Sacramento ED Chief, and Andrew Richardson, Kaiser Roseville and Sacramento ED colleague. Dr. Lee hired respondent in 2015 and describes respondent as "quiet, humble and cares a great deal for the people who come into the [ED]"; and "[m]eticulous in his care." In addition, Dr. Lee has had no quality of care complaints regarding respondent. Dr. Richardson has worked with respondent for more than five years and describes him as "thoughtful, thorough and knowledgeable; a valuable asset in the [ED], [and] a competent physician."

27. Respondent also offered four letters of support, as well as testimony from Drs. Melissa Jones, Kaiser Roseville ED Chief, and David Zinn, a Kaiser Sacramento ED colleague; Nurse Practitioner (NP) Paige Kingman, Kaiser Roseville ED Nurse Manager, and RN Rodney Pebley, Kaiser Sacramento ED Nurse Manager. Dr. Jones described respondent as a very hard worker who provides "good care and cares deeply about his patients, taking the time to listen and understand them." Dr. Jones sees respondent as someone who is kind, with an "upbeat attitude, and no matter what the circumstances of the [ED] are, and it can be chaotic at times, [respondent] is calm and ready to serve his patients or his colleagues." In addition, Dr. Jones has had no quality of care complaints regarding respondent. Dr. Zinn "trust[s] [respondent's] work completely. Dr. Zinn finds respondent to be "meticulous in his patient evaluations. He anticipates potential complications during the next shift. He completes discharge paperwork to help the next doctor. He performs thorough medication reconciliations. He documents conversations with outside consultants. He is clinically strong and maintains a broad differential diagnosis which is consistent with the practice of his peers." NP Kingman and RN Pebley describe respondent as someone

who is thorough and provides excellent care, conducts a complete and thorough patient assessment, quickly makes sound decisions, appropriately orders diagnostic tests, interprets results, and performs appropriate lifesaving interventions. He is empathetic and compassionate; he actively listens to his patient's complaints and makes a genuine interpersonal connection; and he truly cares about the outcome of his patients.

Discussion

28. Patient 1 presented to the ED with a markedly elevated BP, a history of hypertension and a refusal to take his BP medication. Patient 1 also complained of weakness and headache for two weeks with nausea and vomiting, as well as chest pain the night before. Respondent treated Patient 1 as he routinely treats patients presenting with uncontrolled hypertension, by testing for kidney and heart function as well as electrolytes. According to the experts, respondent's standard practice and treatment of Patient 1 involved too little (Dr. Melidonian) or too much (Dr. Snoey) testing.

29. For Dr. Melidonian, Patient 1's elevated BP, coupled with neurological and cardiological complaints, raised concerns for end-organ damage. As such, the standard of care required respondent to test all BP end-organs for damage: brain, heart, kidney, and eyes. Because respondent tested Patient 1 for heart and kidney function only, Dr. Melidonian found he departed from the standard of care when he failed to order a brain MRI or CT and/or administer fast-acting medication to decrease Patient 1's BP in hopes of decreasing any intercranial pressure on the brain, thereby relieving his neurological complaints. Dr. Snoey rejected Patient 1's complaints as too vague, likely unrelated to uncontrolled hypertension, and not indicative of signs or symptoms of end-organ damage. As such, Patient 1 only had uncontrolled

hypertension, making the standard of care to monitor, but not order end-organ or routine tests. As such, Dr. Snoey found respondent's decision to test Patient 1's heart and kidney functions went above what was required for the standard of care.

30. Because Drs. Melidonian and Snoey offered opposing opinions, their findings must be compared, based on qualifications and experience; reasoning and logic; believability and bias; and the facts supporting the basis for their opinions. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.) With due consideration to these factors, Dr. Melidonian's testimony is found to be more persuasive and credible than Dr. Snoey's, in all respects.

31. Both experts are well-qualified, Board-Certified, and come with many years of experience as ED physicians. They both have experience serving on hospital committees reviewing physician and midlevel quality of care and providing executive oversight. Dr. Melidonian has reviewed physician care cases for the Board since 2017, focused on the standard of care, and Dr. Snoey has provided expert testimony in medical malpractice matters, focused on outcomes.

32. The experts agree Patient 1 had uncontrolled hypertension when he presented to the ED; they disagree about how to interpret Patient 1's list of complaints. The experts agree that Patient 1 was diagnosed with hypertension in 2011, making it a chronic condition, unmanaged because he was noncompliant with medication. However, Dr. Melidonian interpreted Patient 1's complaints as an abrupt change in status; two weeks prior, Patient 1 developed a headache, weakness, nausea and vomiting, and for the previous three days, Patient 1 had come home from work early and immediately gone to bed because the symptoms were getting worse, with

chest pain the night before. Dr. Snoey dismissed all of Patient 1's complaints as vague, non-specific, and not signs or symptoms of end-organ damage caused by uncontrolled hypertension. In essence, Dr. Snoey failed to consider that Patient 1's complaints were new and unexpected symptoms that presented exactly two weeks earlier (acute); the complaints worsened in the previous three days; and the fact that all of Patient 1's complaints could be related to BP end-organs: brain, heart, kidney, and eyes. At a minimum, an ED physician should consider all of the complaints raised by a patient and rule them out with examination or testing. When a patient visits an ED, they place their life in the hands of the ED physician, trusting that the ED physician has ample medical expertise but will also listen and actively consider their concerns. Otherwise, a visit to the ED is for naught.

33. In addition, Dr. Melidonian's opinion came with specific and detailed reasoning. She explained why imaging of the brain was necessary and/or the option to order fast-acting BP medication to potentially alleviate the neurological symptoms and thereby eliminate concerns regarding potential damage to the brain. In comparison, Dr. Snoey's testimony was superficial and conclusory. He repeatedly opined that testing of the brain was unnecessary because Patient 1's complaints were not necessarily neurological in etiology and/or were not signs or symptoms of end-organ brain damage. However, it is hard to believe a new, two-week old headache accompanied by nausea, vomiting, and weakness are not symptoms related to the brain in some manner.

34. Ultimately, Dr. Melidonian found respondent made an extreme departure from the standard of care when treating Patient 1, by failing to address the brain; and a simple departure when failing to accurately and adequately chart his encounter. At hearing, respondent was unwilling to concede Patient 1's brain needed testing. He

pointed to his finding of no neurological abnormalities and the fact that Patient 1 did not come to the ED via ambulance and could talk and walk, unlike most stroke patients. However, when Patient 1 complained of abdominal pain, respondent ordered an abdominal CT. Moreover, while respondent's standard practice for a patient with uncontrolled hypertension was to test for heart and kidney function, two end-organs affected by an elevated BP, he never questioned or modified the practice to include the only two other end-organs: brain or eyes. Moreover, with incomplete and inaccurate charting, there is no way to understand and/or explain respondent's medical decision-making at the time and his choice not to expand testing to the brain and eyes, but to include testing of the abdomen. Given the above, the Board is appropriately concerned about respondent's medical decision-making and the completeness of his practice when assessing patients.

35. Finally, Dr. Melidonian found respondent's documentation to be below the standard of care because his charting was incorrect (HPI, ROS and physical examination), incomplete (no abdominal pain or abdominal diagnosis noted; no gait or ability to walk noted), and did not note abnormal test results and his medical decision-making following testing for his final diagnosis. As a result, both experts had to make assumptions about respondent's care and treatment of Patient 1, as would any subsequent providers. Charting is an essential part of medical care, especially in an ED setting, because a patient may return to the ED and need additional care, but will almost undoubtedly see their PCP or a specialist to receive ongoing care for the underlying condition. In this case, respondent's charting was incorrect and incomplete, making it inadequate and not within the standard of care.

Costs

36. Complainant has requested costs of enforcement pursuant to section 125.3 in the total amount of $40,998.75. In support of this request, complainant submitted a Declaration from DAG McEwan with a computer printout of the tasks performed by the Office of the Attorney General, along with an hourly bill from DAG Aaron Lent for 69 hours from January 10, 2022, through May 5, 2022, and from DAG McEwan for 101.75 hours from April 21, 2022, to May 20, 2022. From the information presented, the time and activities appear duplicative for the development and presentation of a one-patient case covering a five-hour window of care. In addition, respondent raised several concerns about his ability to pay costs: he has medical school debt of $400,000, and he is the sole financial support for his seven-person household, including himself, his wife and their four minor children, along with his widowed mother with health issues. Respondent would be forced to obtain a loan to pay costs to the Board.

LEGAL CONCLUSIONS

Standard of Proof

1. To revoke or suspend respondent's medical license, complainant must establish the allegations and violations alleged in the Accusation by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The requirement to produce clear and convincing evidence is a heavy burden, far in excess of the preponderance of evidence standard that is sufficient in most civil litigation. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no

substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

2. Section 2234 requires the Board to "take action against any licensee who is charged with unprofessional conduct." "Unprofessional conduct includes but is not limited to: . . . (b) gross negligence, and (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." (§ 2234, subd. (c).)

3. In addition, section 2266 states: "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

Cause for Discipline

4. Cause exists for disciplinary action under section 2234, subdivisions (b) and (c), by reason of the matters set forth in the Factual Findings as a whole. Complainant proved, by clear and convincing evidence, respondent engaged in gross negligence and repeated negligent acts in his care and treatment of Patient 1 by failing to: (1) obtain a brain MRI or CT and/or administer fast-acting medications to reduce the BP in order to decrease or eliminate the headache; and (2) correctly and thoroughly chart the encounter and his medical decision-making to support his treatment or lack thereof.

5. Cause exists for disciplinary action under section 2266, by reason of the matters set forth in the Factual Findings as a whole. Complainant proved, by clear and convincing evidence, respondent failed to maintain adequate and accurate records for

his encounter with Patient 1 on February 20, 2019, by completing incorrect and insufficient charting of the encounter.

6. Cause exists for disciplinary action under section 2234, generally, by reason of the matters set forth in the Factual Findings and Legal Conclusions as a whole. Complainant proved, by clear and convincing evidence, respondent engaged in unprofessional conduct in his care and treatment of Patient 1 and his documentation of the same.

7. Considering the Factual Findings and Legal Conclusions as a whole, respondent's actions constitute cause for discipline. However, with monitoring and guidance, respondent can provide medical care to patients without harm to the public.

Costs of Enforcement

8. Pursuant to section 125.3, a licensee found to have violated a licensing act may be ordered to pay the reasonable costs of investigation and enforcement of a case. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth factors to be considered in determining the reasonableness of the costs sought pursuant to statutory provisions like section 125.3. These factors include: (1) whether the licensee has been successful at hearing in getting charges dismissed or reduced; (2) the licensee's subjective good faith belief in the merits of his or her position; (3) whether the licensee has raised a colorable challenge to the proposed discipline; (4) the financial ability of the licensee to pay; and, (5) whether the scope of the investigation was appropriate in light of the alleged misconduct.

9. As set forth in Factual Finding 36, complainant seeks enforcement costs in the amount of $40,998.75. Respondent objected to the costs, finding the amount to

be excessive and the itemized hours billed appear to be duplicative between two DAGs. In addition, respondent indicates he is unable to pay costs. He has a large medical school debt and is the sole financial income for a household of seven. Respondent believes paying these costs would be a tremendous hardship and he would be required to secure a loan at the expense of other necessities, but he would find a way to pay the amount awarded to the Board. When the *Zuckerman* factors and respondent's ability to pay are considered, the costs are deemed disproportionate to the scope and enforcement of this matter. In addition, the seemingly duplicative billing is a concern.

10. After consideration of the factors under *Zuckerman*, the amount of time billed, and considering respondent's inability to pay, the enforcement costs in this matter are reduced to $21,000. Respondent shall pay to the Board the costs associated with its enforcement pursuant to section 125.3 in the amount of $21,000.

ORDER

Physician's and Surgeon's Certificate No. A 39604 issued to respondent Zane Aaron Shaeffer, M.D., is REVOKED. However, the revocation is STAYED, and respondent is placed on probation for three years upon the following terms and conditions:

1. Education Courses

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, 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 40 hours per year, for each year of probation. 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 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Medical Record-Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six 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 CME requirements for renewal of licensure.

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

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course,

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

3. Practice Monitoring

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and

copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum,

quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

4. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, respondent's practice setting changes and respondent is no longer practicing in a setting in compliance with this Decision, respondent shall notify the Board or its designee within five calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

5. Notification

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

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

6. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

7. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. General Probation Requirements

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

10. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

11. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or

jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

12. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

13. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

15. Probation Monitoring and Enforcement Costs

Respondent shall pay the costs associated with the enforcement of this matter in the amount of $21,000. Respondent may negotiate a payment plan with the Board. In addition, respondent shall pay probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis.

Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATE: July 11, 2022

ERIN R. KOCH-GOODMAN
Administrative Law Judge
Office of Administrative Hearings

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
AARON L. LENT
Deputy Attorney General
State Bar No. 256857
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7545
Facsimile: (916) 327-2247

Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **ZANE AARON SHAEFFER, M.D.** **815 Taylor Rd.** **Newcastle, CA 95658-9780** **Physician's and Surgeon's Certificate No. A 135109,** Respondent.	Case No. 800-2019-056976 OAH No. 2021120394 **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 or about March 16, 2015, the Medical Board issued Physician's and Surgeon's Certificate No. A 135109 to Zane Aaron Shaeffer, 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 September 30, 2022, unless renewed.

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:

> "The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> "(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> "(b) Gross negligence.
>
> "(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> "(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> "(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> "...
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
>
> ".."

6. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical conduct of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an

unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 25 575.)

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.

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

9. Respondent is a physician and surgeon, board certified in emergency medicine, who at all times relevant to the allegations brought herein worked at the Kaiser Permanente Roseville Medical Center in Roseville, California.

10. On or about February 20, 2019, at approximately 7:07 p.m., Patient 1,[1] a 38-year old male with a history of hypertension; obesity; and hyperlipidemia, and his wife, arrived by private vehicle to the emergency department at the Kaiser Permanente Roseville Medical Center with the chief complaint of hypertension. Prior to this date, Patient 1 had been prescribed amlodipine[2] 10 mg daily with fenofibrate and acetaminophen by his primary care physician.

11. Patient 1's vitals upon arrival were documented as having a blood pressure of 213/139, heart rate of 88, respiration rate at 16, temperature was 98.6° F, and oxygen saturation of 99% on room air.

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[1] To protect the privacy of the patient, the patient's and witness' names and information were not included in this pleading. Respondent is aware of Patient 1's and the witness' identities. All witnesses will be fully identified in discovery.

[2] Amlodipine is a drug that belongs to the drug class of calcium channel blockers (CCBs), and is prescribed for the treatment and prevention of angina (heart or chest pain) that results from coronary spasm and from coronary artery disease. It is also used with or without other medications to treat high blood pressure.

12. At approximately 7:10 p.m., triage nurse N.M., R.N., documented that Patient 1 had weakness and headaches for two weeks prior, accompanied by nausea and vomiting with elevated blood pressure lately, as well as chest pains the night prior to February 20, 2019.

13. At approximately 7:46 p.m., Patient 1 was seen by Respondent who noted Patient 1's history of hypertension, daily smoking habit, history of asthma with some nausea and vomiting without fever, and his noncompliance with taking his blood pressure medication. Respondent also noted Patient 1 had complaints of not feeling well, generalized weakness during the prior three weeks, and a history of his present illness.

14. In Patient 1's medical record review of systems, Respondent marked all negative, including: head, eyes/ears, nose, and throat (HENT); negative for headaches, ear pain and sore throat; negative for chest pain, palpitations and leg swelling; negative for nausea, vomiting, abdominal pain, diarrhea and constipation; and negative for dizziness and focal weakness.

15. Respondent's initial impression and medical decision making mentioned Patient 1's weakness and headache with a differential diagnoses of tension headache, migraines, sinusitis, subarachnoid hemorrhage, intracranial hemorrhage, trauma or meningitis.

16. At approximately 7:44 p.m., Respondent ordered a computed tomography (CT) scan of Patient 1's abdomen and pelvis, in addition to ordering aspirin at 325 mg orally, which surge nurse P.D., R.N., commented was contraindicated with a possible bleed and, consequently was not administered.

17. At approximately 10:42 p.m., Respondent ordered amlodipine 10 mg orally and acetaminophen 1000 mg orally to be administered to Patient 1 with the intention of bringing Patient 1's blood pressure down by 10-20%. Respondent noted in the medical records of Patient 1 "Treatment: IV, monitor."

18. Patient 1's medical records reflect Respondent's assessment and plan as hypertension and to take amlodipine at 10 mg. Respondent attributed Patient 1's weakness to hypertension and noted that Patient 1 also appeared depressed. Respondent's final diagnosis of Patient 1 was hypertension weakness. Patient 1 remained in the surge waiting area or hallway bed of the hospital until the time of his discharge at approximately 12:13 a.m. the following day.

19. Prior to Patient 1's discharge from the hospital, at approximately 11:36 p.m., a nursing note by M.O., R.N. stated that Respondent was aware of Patient 1's blood pressure of 211/129 with a heart rate of 73, and approved of Patient 1's discharge.

20. Respondent provided no explanation in the medical documentation for the imaging of Patient 1's abdomen and pelvis other than to rule out diverticulitis. The CT scan subsequently yielded a result of no acute abnormalities seen in the abdomen and pelvis of Patient 1. Respondent believed that a head CT scan of Patient 1 was not indicated based on the patient's labs and clinical examination.

21. An electrocardiogram (EKG) was performed on Patient 1 on or about February 20, 2019, and officially read on the following day; however, was not specifically mentioned by Respondent in his documentation. Patient 1's EKG showed sinus rhythm nonspecific T abnormalities, lateral leads with borderline ST elevation, and anterior leads. Similarly, there was no specific documentation about Patient 1's chest x-ray performed at approximately 8:12 p.m. by Respondent; however, the cardiac silhouette was noted to be normal in size and contour with no other abnormalities noted.

22. Throughout Patient 1's treatment on or about February 20, 2019, Patient 1's blood pressure remained elevated. Specifically, at 7:13 p.m. his blood pressure was 213/139 with a heart rate of 88; at 7:15 p.m. his blood pressure was 223/153; at 10:41 p.m. his blood pressure was 203/132 with a heart rate of 78; and at 11:14 p.m. his blood pressure was 211/129 with a heart rate of 73.

23. On or about February 23, 2019, Patient 1, returned to the emergency department at the Kaiser Permanente Roseville Medical Center with the chief complaint of hypertension and a headache. The treating physician documented that Patient 1 stated "my head has been hurting for two weeks now" with throbbing on the right side of his head and back with an initial blood pressure upon arrival at 176/104. Patient 1 also indicated he suffered from back pain, nausea without vomiting, and had been unable to lower his blood pressure below 190/116.

24. On or about February 23, 2019, when Patient 1 returned to the emergency department at the Kaiser Permanente Roseville Medical Center, he was treated by E.G., M.D., who

documented Patient 1 appeared sleepy during his physical examination, and ordered Patient 1 undergo a CT scan of his head.

25. Patient 1's head CT scan revealed a parenchymal hemorrhage at the left basal ganglia measuring 2.8 x 1.5 x 2.4 cm, with an estimated volume of 5 mL. The CT scan also evidenced mild surrounding parenchymal edema and mild mass effect on the left lateral ventricle with no significant midline shift.

26. Patient 1 was thereafter admitted to the intensive care unit at Kaiser Permanente Roseville Medical Center for blood pressure management, serial neurological exams, and repeat imaging within 24 hours. Patient 1 was documented as presenting in a hypertensive emergency with a head CT scan revealing subacute hypertensive hemorrhagic stroke that was estimated to be a week or more since its occurrence.

27. A magnetic resonance imaging (MRI) of Patient 1's brain was also performed, which revealed left-sided parenchymal hematoma and a Moyamoya pattern with severe stenosis or occlusion of the terminal internal carotid artery, middle cerebral artery, and proximal anterior cerebral arteries bilaterally. The MRI also evidenced chronic ischemic changes and few foci of remote hemorrhage. No additional work-up was performed during this hospitalization of Patient 1 regarding the Moyamoya pattern noted on the imaging studies.

28. Patient 1 was hospitalized at Kaiser Permanente Roseville Medical Center on or about February 23, 2019 through February 27, 2019, due to difficulty in controlling his blood pressure. Patient 1 was discharged on or about February 27, 2019, while on four different antihypertensive medications.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

29. Respondent Zane Aaron Shaeffer, M.D. has subjected his Physician's and Surgeon's Certificate No. A 135109 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient 1 as more particularly alleged hereafter: The circumstances are as follows:

30. Complainant re-alleges paragraphs 9 through 28, and those paragraphs are incorporated by reference as if fully set forth herein.

31. Respondent's care and treatment of Patient 1 departed from the standard of care in that:

A. During Respondent's treatment and care of Patient 1 on or about February 20, 2021, Respondent failed to appreciate and appropriately react to Patient 1's symptoms and blood pressure values that were higher than the typical cutoffs to indicate a hypertensive crisis and/or hypertensive emergency with Patient 1's systolic blood pressure greater than or equal to 180 mm Hg and his diastolic blood pressure greater than or equal to 110 mm Hg;

B. While Patient 1 displayed signs and symptoms consistent with hypertensive emergency given his nausea, lethargy, headache and weakness, Respondent failed to obtain the necessary studies to exclude a subarachnoid hemorrhage, intracranial hemorrhage, or hypertensive encephalopathy;

C. Respondent did not immediately begin to administer antihypertensive medications to Patient 1 from the initial evaluation at approximately 7:46 p.m. but, waited almost three hours until he ordered the amlodipine at approximately 10:42 p.m.;

D. Respondent administered a medication (amlodipine) that is not rapid-acting after Patient 1 continued to have severely elevated blood pressure readings after his arrival in the emergency department;

E. Respondent failed to appropriately manage and treat Patient 1's hypertension by failing to further test to evaluate Patient 1 for end-organ damage, specifically for concern of ischemic or hemorrhagic stroke, increased intracranial pressure, myocardial infarction, or aortic dissection by way of an MRI or CT scan of Patient 1's brain and head;

F. While Respondent listed subarachnoid or intracranial hemorrhage as a possibility in Patient 1's differential diagnoses, Respondent failed to order a CT scan of Patient 1's head to rule these out, and failed to articulate his reasoning for not proceeding with additional tests to exclude them;

G. Patient 1's medical record documentation by Respondent was performed using electronic templates and does not accurately reflect all the current and complete information for Patient 1, the pertinent physical findings, and the decision making related to all the tests ordered and reviewed. More specifically:

i. the medical record fails to include all of Patient 1's previous medical records;

ii. Patient 1's smoking history is contradictory given that Respondent noted Patient 1 smoked daily; however, the social history note of Patient 1's records stated he quit smoking in 2017;

iii. In the triage note and the HPI, there is mention of generalized weakness, headache, nausea, vomiting, in addition to other complaints by Patient 1; however, Respondent documented an entirely negative review of symptoms without pertinent positives;

iv. There is insufficient discussion or medical decision making in Patient 1's medical records by Respondent to address the vague neurological complaints of headache, nausea, vomiting and lethargy, and specifically what led Respondent to exclude the diagnoses of subarachnoid or intracranial hemorrhage and hypertensive emergency;

v. In the physical exam section of Patient 1's medical records, Respondent documented a standard normal physical exam with no distress, yet the patient's wife noted that Patient 1 was having difficulty staying awake to answer Respondent's questions and that Patient 1 was wheeled between rooms at the hospital;

vi. Nurse P.D., R.N., noted Patient 1 as being a fall risk for nursing judgement when he first arrived on or about February 20, 2019. Conversely, Respondent documented Patient 1 as alert and oriented with normal reflexes, no cranial nerve deficit and exhibited normal muscle tone and coordination despite no documentation in the medical record specifically mentioning Patient 1's gait or ability to walk;

vii. Patient 1's medical records fail to indicate in the ED Provider note why the CT scan of Patient 1's abdomen and pelvis were ordered by Respondent, and no differential diagnoses were specifically centered on intra-abdominal causes for Patient 1's nausea and pain; and

viii. Respondent failed to sufficiently document his interpretations and the ramifications regarding the electrocardiogram and the chest x-ray results of Patient 1.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

32. Respondent Zane Aaron Shaeffer, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 135109 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient 1, as more particularly alleged in paragraphs 9 through 31, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

33. Respondent Zane Aaron Shaeffer, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 135109 to disciplinary action under sections 2227 and 2234, as defined by section 2266 of the Code, in that he failed to maintain adequate and accurate medical records for Patient 1, as more particularly alleged in paragraphs 9 through 31, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

34. Respondent Zane Aaron Shaeffer, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 135109 to disciplinary action under sections 2227 and 2234, as defined by section 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming of a member in good standing to his care and treatment of Patient 1 in addition to his overall conduct, as more

particularly alleged in paragraphs 9 through 31, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 135109, issued to Respondent Zane Aaron Shaeffer, M.D.;

2. Revoking, suspending or denying approval of Respondent Zane Aaron Shaeffer, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Zane Aaron Shaeffer, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: MAR 18 2022

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

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