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

In the Matter of the Accusation Against:	)	
Wu-Hsiung Su, M.D.	)	Case No. 02-2008-193016
Physician's and Surgeon's Certificate No. A 33249	)	
Respondent	)	

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted by the Medical Board of California, Department of Consumer Affairs, State of California as its Decision in the above entitled matter.

This Decision shall become effective at 5:00 p.m. on October 14, 2011.

IT IS SO ORDERED October 7, 2011.

MEDICAL BOARD OF CALIFORNIA

By: _____
Linda K. Whitney
Executive Director

KAMALA D. HARRIS
Attorney General of California
GAIL M. HEPPELL
Supervising Deputy Attorney General
ROBERT C. MILLER
Deputy Attorney General
State Bar No. 125422
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-5161
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 Accusation Against: **WU-HSIUNG SU, M.D.** **3336 Bordeaux Drive** **El Dorado Hills, CA 95762** **Physician's and Surgeon's Certificate No. A33249** Respondent.	Case No. 02-2008-193016 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties in this proceeding that the following matters are true:

PARTIES

1. Linda K. Whitney (Complainant) is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Robert C. Miller, Deputy Attorney General.

2. WU-Hsiung Su, M.D. (Respondent) is represented in this proceeding by attorney Timothy J. Aspinwall, whose address is NOSSAMAN LLP Attorneys at Law, 915 L Street Sacramento, CA 95814.

3. On or about November 29, 1978, the Medical Board of California issued Physician's and Surgeon's Certificate No. A33249 to WU-Hsiung Su, M.D. (Respondent). Said license will expire on December 11, 2011 unless renewed.

On November 2, 2010, a Petition for Interim Suspension was filed against Respondent. The Petition was based on the facts and allegations in Medical Board Case Nos. 02-2008-193016, 02-2010-207090, and 02-2010-207092. On November 3, 2010 the Petition was granted and Respondent's license was suspended. On November 15, 2010, respondent waived his right to hearing on the interim suspension.

JURISDICTION

3. Accusation No. 02-2008-193016 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on July 1, 2010. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 02-2008-193016 is attached as Exhibit A and incorporated by reference. Medical Board Case Nos. 02-2010-207090 and 02-2010-207092 are also pending against Respondent and were included and incorporated in The Petition for Interim Suspension Order filed against Respondent on November 2, 2010. A copy of Petition for Interim Suspension is attached as Exhibit B and incorporated by reference. This stipulation is intended to incorporate and resolve all three pending cases referenced above.

ADVISEMENT AND WAIVERS

4. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 02-2008-193016 as well as the allegations in the Petition for Interim Suspension. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

5. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel

the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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

CULPABILITY

7. Respondent understands that the charges and allegations in Accusation No. 02-2008-193016, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

8. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a prima facie factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

9. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

10. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

11. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails

to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that facsimile copies of this Stipulated Surrender of License and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A33249, issued to Respondent WU-Hsiung Su, M.D., is surrendered and accepted by the Medical Board of California.

14. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

15. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

16. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

17. For purposes of avoiding the expense and uncertainty of litigation in this matter, Respondent agrees to the following: If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Pursuant to the Board's order of interim suspension, Respondent's physician's and surgeon's certificate has been suspended and he has not engaged in the practice of medicine since November 3, 2010. In consideration of the duration of that suspension and for good cause shown, Respondent is eligible to file a petition for reinstatement of license after two years from the

effective date of this decision. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 02-2008-193016, as well as the First, Second, Third, and Fourth Causes for Issuance of an Interim Suspension Order as alleged in the Petition for Interim Suspension filed on November 2, 2010, shall be deemed to be true and correct when the Board determines whether to grant or deny the petition, except that Respondent did, in fact, examine patients Daniel Frizzell and Craig Miller for their presenting symptoms on the dates alleged.

ACCEPTANCE

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

DATED: 08-22-2011

WU-HSIUNG SU, M.D.
Respondent

I concur with this stipulated surrender.

DATED: 8/22/11

TIMOTHY J. ASPINWALL
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: February 3, 2011

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
GAIL M. HEPPELL
Supervising Deputy Attorney General

ROBERT C. MILLER
Deputy Attorney General
Attorneys for Complainant

SA2010100620
Stipulation.rtf

Exhibit A

Accusation No. 02-2008-193016

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 1 2010
BY Brenda Allen ANALYST

EDMUND G. BROWN JR.
Attorney General of California
GAIL M. HEPPELL
Supervising Deputy Attorney General
ROBERT C. MILLER
Deputy Attorney General
State Bar No. 125422
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-5161
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 Accusation Against: **WU-HSIUNG SU, M.D.** **2828 Mills Park Drive, Suite D** **Rancho Cordova, CA 95670** **Physician's and Surgeon's Certificate No. A33249** Respondent.	Case No. 02-2008-193016 **ACCUSATION**

Complainant alleges:

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

2. On or about November 29, 1978 the Medical Board of California issued Physician's and Surgeon's Certificate Number A33249 to Wu-Hsiung Su, 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 December 31, 2011 unless renewed.

///

///

///

JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All Section references are to the Business and Professions 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 Division[1] deems proper.

5. Section 2234 of the Code states:

"The Division of Medical Quality 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:

"(b) Gross negligence."

"(c) Repeated negligent acts."

"(d) Incompetence

6. Section 2266 of the code provides that failure to maintain adequate patient records constitutes unprofessional conduct.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)
[Bus. & Prof. Code § 2234(b)]

7. Respondent is subject to disciplinary action under Section 2234(b) of the Code in that his care and treatment of patient R.A.[2] was grossly negligent. The circumstances are as follows:

8. On April 9, 2001, Respondent, a physician at We-Care Medical Center in Rancho Cordova, California, became the primary physician for patient R.A., a 60-year-old woman.

---

[1] California Business and Professions Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Cal. Bus. & Prof. Code §§ 2000, et. seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

[2] Patient names are abbreviated herein to protect patient confidentiality. Patients' full names will be provided upon receipt of a properly executed and served Request for Discovery.

9. Respondent saw R.A. almost monthly from April 9, 2001, until her last visit with him on November 5, 2004. R.A. had a medical history of hypertension, depression, anxiety, osteoarthritis, tobacco use, and chronic obstructive pulmonary disease.

10. On November 7, 2001, Respondent performed an endovaginal ultrasound on R.A. due to her complaint of urinary urgency and lower abdominal pain.

11. On April 11, 2002, Respondent performed an echocardiogram on R.A. and found "moderate aortic insufficiency".

12. On July 2, 2003, R.A. underwent a mammogram with direction that the imaging be repeated in 6 months. Nothing in the patient's chart indicates that respondent notified or discussed this with R.A.

13. On May 7, 2004, a lump was found by Respondent's medical assistant in R.A.'s left breast. Respondent performed an in-office ultrasound of the breast and noted no abnormality except "fibrocystic changes". Records are silent as to any discussion with R.A. or follow-up plan of further diagnosis or treatment.

14. R.A. was seen by Respondent 5 more times after May 7, 2004, but no further mention was made of the lump in R.A.'s breast nor was there any discussion of a repeat mammogram.

15. In October of 2005, R.A. had changed her primary care physician. She underwent a mammogram that identified a 2 cm mass in her left breast. A further CT scan demonstrated metastasis and R.A. died from her cancer on September 27, 2007.

16. Respondent's care and treatment of patient R.A. was grossly negligent within the meaning of section 2234, subdivision (b) of the Code as follows:

> Respondent's failure to notify the patient of abnormal mammogram results, failure to document the result of the mammogram and follow-up plan in the patient's chart, and failure to order appropriate follow-up studies, constitutes an extreme departure from the standard of care.

///

///

///

///

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)
[Bus. & Prof. Code § 2234(b)]

17. Paragraphs 7 through 15 are repeated here as fully set forth above.

18. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code in that his care and treatment of patient R.A. was grossly negligent. The circumstances are as follows:

When R.A. reported a lump in her breast during her May 7, 2004 visit, Respondent's failure to perform a proper physical examination, including a thorough breast and lymph exam; his failure to refer R.A. for a mammogram; and his reliance alone on the use of his ultrasound to diagnose the lump, constitutes an extreme departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)
[Bus. & Prof. Code § 2234(b)]

19. Paragraphs 7 through 15 are repeated here as fully set forth above.

20. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code in that his care and treatment of patient R.A. was grossly negligent. The circumstances are as follows:

Respondent performed and interpreted an echocardiogram on R.A. without the appropriate training which is an extreme departure from the standard of care.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence)
[Bus. & Prof. Code § 2234(b)]

21. Paragraphs 7 through 15 are repeated here as fully set forth above.

22. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code in that his care and treatment of patient R.A. was grossly negligent. The circumstances are as follows:

Respondent performed and evaluated several abdominal, pelvic and breast ultrasounds on R.A. without the appropriate training which constitutes an extreme departure from the standard of care.

///

///

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence)
[Bus. & Prof. Code § 2234(b)]

23. Paragraphs 7 through 15 are repeated here as fully set forth above.

24. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code in that his care and treatment of patient R.A. was grossly negligent. The circumstances are as follows:

Respondent's record keeping and patient charting is so insufficient that it constitutes an extreme departure from the standard of care.

SIXTH CAUSE FOR DISCIPLINE

(Repeated Negligence Acts)
[Bus. & Prof. Code § 2234(c)]

25. Paragraphs 7 through 24 are repeated here as fully set forth above.

26. Respondent is subject to disciplinary action under Section 2234(c) of the Code in that he committed acts of repeated negligence in any two or more of the departures from the standard of care in his care and treatment of R.A. as detailed above and summarized as follows:

a) Respondent's failure to notify the patient of abnormal mammogram results, failure to document the result of the mammogram and follow-up plan in the patient's chart, and failure to order appropriate follow-up studies, constitutes a departure from the standard of care.

b) When R.A. reported a lump in her breast during her May 7, 2004 visit, Respondent's failure to perform a proper physical examination, including a thorough breast and lymph exam; his failure to refer R.A. for a mammogram; and his reliance alone on the use of his ultrasound to diagnose the lump, constitutes a departure from the standard of care.

c) Respondent performed and interpreted an echocardiogram on R.A. without the appropriate training which is a departure from the standard of care.

d) Respondent performed and evaluated several abdominal, pelvic and breast ultrasounds on R.A. without the appropriate training which constitutes a departure from the standard of care.

e) Respondent's record keeping and patient charting is so insufficient that it constitutes a departure from the standard of care.

///

///

SEVENTH CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)
[Bus. & Prof. Code § 2266]

27. Paragraphs 7 through 15 are repeated here as fully set forth above.

28. Respondent is subject to disciplinary action under section 2266 of the Code in that his charting of the care and treatment he provided patient R.A. was inadequate and incomplete which constitutes unprofessional conduct.

EIGHTH CAUSE FOR DISCIPLINE

(Incompetence)
[Bus. & Prof. Code § 2234(d)]

29. Paragraphs 7 through 15 are repeated here as fully set forth above.

30. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code in that his care and treatment of patient R.A. was incompetent. The circumstances are as follows:

> Respondent's performance and interpretation of ultrasound and echocardiograms on patient R.A were so lacking in detail and accuracy as to indicate respondent's lack of knowledge and training in the proper use of these diagnostic procedures which constitutes incompetence.

PRAYER

WHEREFORE, Complainant request that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Physician's and Sugeon's Certificate No. A33249, issued to Wu-Hsiung Su, M.D.

2. Revoking, suspending or denying approval of Wu-Hsiung Su, M.D.'s authority to supervise physician assistants, pursuant to Section 3527 of the Code.

///

///

///

///

///

3. Ordering Respondent, Wu-Hsiung Su, M.D. to pay costs of probation monitoring if probation is imposed; and

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

DATED: 7/1/2010

LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SA2010100620
10586154.doc

Exhibit B

Petition for Interim Suspension

EDMUND G. BROWN JR.
Attorney General of California
GAIL M. HEPPELL
Supervising Deputy Attorney General
ROBERT C. MILLER
Deputy Attorney General
State Bar No. 125422
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916)
Facsimile: (916) 327-2247
Attorneys for Petitioner

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

LINDA K. WHITNEY, Executive Director, Medical Board of California, Petitioner, **WU-HSIUNG SU, M.D.** 3336 Bordeaux Drive El Dorado Hills, California 95762 Physician's and Surgeon's Certificate Number A33249 Respondent.	OAH No. **PETITION FOR EX PARTE INTERIM SUSPENSION ORDER; EXHIBITS** [Government Code Section 11529] **Date: Wednesday November 3, 2010** **Time: 1:00 p.m.** **Place: Office of Administrative Hearings** **2349 Gateway Oaks Drive, Ste. 200** **Sacramento, CA 95833**

Linda K. Whitney ("Petitioner") makes and files the instant Petition for Ex Parte Interim Suspension Order ("Petition") against the Physician's and Surgeon's Certificate of Wu-Hsiung Su, M.D., ("Respondent"), solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, State of California ("Board"). Petitioner is represented in this matter by Edmund G. Brown Jr., Attorney General of the State of California, and by Deputy Attorney General Robert C. Miller.

As will be demonstrated, and as supported by the accompanying exhibits, permitting Respondent to continue practicing medicine at this time constitutes a danger to the public. The likelihood of injury to the public in not issuing the order outweighs the likelihood of injury to Respondent should the order issue.

I

PARTIES

1. Petitioner is the Executive Director of the Board, and is authorized to make this Petition on behalf of the Board in furtherance of the Board's duties.

2. On or about November 29, 1978 the Board issued Physician's and Surgeon's certificate number A33249 ("license") to Respondent. At all times relevant to this proceeding, Respondent's license was valid. The license will expire unless renewed on December 31, 2011. (Exhibit 1.) On January 10, 1996 Respondent's license was "REVOKED, STAYED, FIVE YEARS PROBATION WITH TERMS AND CONDITIONS." On December 3, 2001 probation was completed. (Exhibit 1.)

II

JURISDICTION

3. Government Code section 11529(a) provides the authority for an administrative law judge of the Medical Quality Hearing Panel to issue an interim order suspending the medical license of a physician. The order may be issued if affidavits in support of the petition for an interim suspension order show that the physician has engaged in, or is about to engage in, acts constituting a violation of the Medical Practice Act or other relevant practice acts, or that the physician is unable to practice safely due to a mental or physical condition, and that permitting the physician to continue to engage in the practice of medicine will endanger the public health, safety, or welfare.

4. An order suspending a physician's license pursuant to Government Code section 11529(a) may generally only be issued after a hearing conducted with at least 15 days' prior notice to the licensee. However, under Government Code section 11529(b), the order may be granted on an *ex parte* basis where it appears from the facts demonstrated by affidavit that serious injury would result to the public before the matter can be heard on regular notice. Government Code section 11529(c) provides that when an interim suspension order is granted on an *ex parte*

basis, the licensee is entitled to a noticed hearing on the suspension order within 20 days of issuance.

5. Pursuant to Business and Professions Code section 2234, the Board shall take disciplinary action against the license of any physician who is charged with unprofessional conduct.

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[1] deems proper.

5. Section 2234 of the Code states:

"The Division of Medical Quality 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:

"(b) Gross negligence."

"(c) Repeated negligent acts."

"(d) Incompetence

6. Section 2266 of the code provides that failure to maintain adequate patient records constitutes unprofessional conduct.

/////

/////

/////

/////

/////

---

[1] California Business and Professions Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Cal. Bus. & Prof. Code §§ 2000, et. seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

III

CAUSE FOR ISSUANCE OF INTERIM SUSPENSION ORDER

7. Respondent, Dr. Wu-Hsiung Su, has a nearly 20 year history of grossly negligent and incompetent medical practice. He has had his medical license in a sister-state twice disciplined and ultimately revoked for missing diagnoses for patients in his care which lead to patient harm. On February 13, 1991, Respondent's license in the state of Rhode Island was disciplined for unprofessional conduct in the practice of medicine due to his improper diagnosis and treatment of a patient. The patient went to see Respondent with a complaint of lower back pain. Respondent prescribed muscle relaxants and warm pack and advised the patient to call if the pain persisted. Approximately 10 days later, the patient underwent emergency surgery for spinal cord compression. He suffered permanent neurological damage. It was found that Respondent failed to obtain a timely consultation and to recognize the severity of the patient's medical problem. Respondent was ordered to complete no less than ten classroom hours of instruction in neurological evaluation. (Exhibit 2: Declaration of Senior Investigator Anna Vanderveen.)

8. On September 30, 1993, Respondent's medical license in Rhode Island was disciplined once again for unprofessional conduct in the practice of medicine. Respondent treated a patient who responded to his newspaper solicitation for his weight loss program. He treated the patient with appetite suppressants, diuretics and vitamin B-12. Respondent's treatment was found not to comport with standards of care for a weight loss program. At some point during treatment, the patient complained of itchiness and sores or her scalp. Respondent attributed this to ticks on the family pets and prescribed a treatment shampoo. The condition persisted and was left untreated by Respondent. The patient further complained of frequent urination and excessive thirst. Respondent attributed these complaints to the diuretic he had been prescribing the patient and did nothing to alleviate the patient's symptoms, nor did he record these complaints and symptoms in the patient's chart. Respondent did not order a urine test, and he failed to discuss with the patient any results of three blood tests which were conducted. Respondent failed to recognize that the patient had early symptoms of Diabetes. The patient eventually admitted herself to a hospital and was diagnosed with Diabetes Mellitus. (Exhibit 2.)

9. Based on that unprofessional conduct, Respondent's medical license was

suspended by the Rhode Island Medical Board until he completed educational course, in adult metabolic and endocrine diseases, management of obesity, and "medical records, including documentation of patient histories, symptoms and/or complaints and treatments undertaken". However, before the Rhode Island decision and disciplinary order was even issued, Respondent moved to California in 1993. Respondent had been first licensed in California in 1978, let his license expire in 1989, and had his license later renewed on January 29, 1994.

10. Respondent has had his license previously disciplined in California with remedial testing and educational requirements imposed as terms of probation. In 1995, Accusation No. 16-91-14733 was filed against Respondent's California license based on the Rhode Island discipline. After an administrative hearing on the accusation (OAH No. N-9504126), the Decision in case no. 16-91-14733 became effective on January 10, 1996. In that decision, Respondent's license was placed on probation for five years under the following terms and conditions: maintain a drug log, take an additional 40 hours of Continuing Medical Education per each year of probation, take a course in ethics, take and pass an oral clinical examination, obtain a practice monitor, and comply with the standard terms and conditions. (Exhibit 2.)

11. Respondent twice failed the oral clinical examination ordered in case no. 16-91-14733 and was suspended from practice. Respondent took his first oral clinical examination on April 12, 1996. He failed that exam with scores of 59 percent and 68 percent; a passing score is 70 percent. He was told he had to close his practice down as of May 24, 1996. On September 4, 1996, he failed his second oral clinical examination with scores of 64 percent and 59 percent. On June 2, 1997, he finally passed his third oral clinical examination. Respondent informed the Board that he was leaving for Taiwan after the exam and would not be returning until August, 1997. In August, 1997, Respondent was notified through his attorney he passed his third oral clinical exam and that he could not engage in solo practice and would need a practice monitor. Respondent returned to California on January 23, 1998 and obtained a practice monitor on June 3, 1998. (Exhibit 2.)

12. Respondent was found to have violated his practice monitor requirement in 2000 by working in Yuba City on his own and the violation resulted in a cite and fine for making false statements in his quarterly reports to probation.

13. In 2004, after a Medi-Cal audit by the California Department of Heath Services, Respondent had his Medi-Cal provider privileges cancelled in California due to his incompetent use of medical testing and treating technologies, and failure to document in patient records even

the most basic of information on histories, physicals and symptoms of presenting problems. The Medi-Cal audit of Respondent found that he was doing echocardiograms without the required six-month training program. Reviewing patient records in was found that Respondent presented potential harm to the patients because he was not qualified to read the echocardiograms and had misinterpreted results. In addition, a Medi-Cal expert stated that Respondent needed to use anesthesia for colonoscopies and that he had not been giving anesthesia during colonoscopy procedures in his office. The audit also found numerous deficiencies in Respondent's medical record-keeping. He failed to document any rectal examination at any visits prior to the colonoscopy and there is no documentation of any kind of prep before the procedure or any preoperative instructions for the patient. One procedure was done using Versed, but there are no conscious sedation progress notes, no documentation of any monitoring, and no notes on recovery. Pulmonary function tests were done without documentation of medical necessity. Ultrasounds of abdomen and prostate were done without rectal examinations. (Exhibit 2.)

14. As a result of losing his Medi-Cal provider number, Respondent took the Physician Assessment and Clinical Education Program (PACE) recordkeeping class in 2005.

15. Finally, the most recent complaints of grossly negligent and incompetent medical care by Respondent involve three patients, two of whom died. Necessary and potentially life-saving treatments were delayed as a result of Respondent's failure to properly examine, diagnose, and treat these patients. Based on his departures from the standard of care and treatment of his patients, Respondent is subject to disciplinary action under Section 2234(b) of the Code. The circumstances are as follows:

FIRST CAUSE FOR ISSUANCE OF AN INTERIM SUSPENSION ORDER

(Gross Negligence)
[Bus. & Prof. Code § 2234(b)]

Patient Aleman

7. On July 17, 2008 the California Medical Board received a complaint from Jessica Aleman- Reed regarding Ms. Reed's mother, Ruth Aleman who had died of breast cancer on September 27, 2007. Respondent, a physician at We-Care Medical Center in Rancho Cordova, California, became the primary physician for Mrs. Aleman, a 60-year-old woman, in April, 2001. A financial settlement based on the death between Mrs. Aleman's estate and Respondent was received on July 14, 2008. (Exhibit 2.)

8. Respondent saw Mrs. Aleman almost monthly from April 9, 2001, until her last visit with him on November 5, 2004. Mrs. Aleman had a medical history of hypertension, depression, anxiety, osteoarthritis, tobacco use, and chronic obstructive pulmonary disease. (Exhibit 3: Declaration of Dr. Craig Keenan.)

10. On November 7, 2001, Respondent performed an endovaginal ultrasound on Mrs. Aleman due to her complaint of urinary urgency and lower abdominal pain.

11. On April 11, 2002, Respondent performed an echocardiogram on Mrs. Aleman and found "moderate aortic insufficiency".

12. On July 2, 2003, Mrs. Aleman underwent a mammogram with direction that the imaging be repeated in 6 months. Nothing in the patient's chart indicates that respondent notified or discussed this with Mrs. Aleman.

13. On May 7, 2004, a lump was found by Respondent's medical assistant in Mrs. Aleman's left breast. Respondent performed an in-office ultrasound of the breast and noted no abnormality except "fibrocystic changes". Records are silent as to any discussion with Mrs. Aleman or follow-up plan of further diagnosis or treatment.

14. Mrs. Aleman was seen by Respondent five more times after May 7, 2004, but no further mention was made of the lump in Mrs. Aleman's breast nor was there any discussion of a repeat mammogram.

15. In October of 2005, Mrs. Aleman had changed her primary care physician. She underwent a mammogram that identified a 2 cm mass in her left breast. A further CT scan demonstrated metastasis and Mrs. Aleman died from her cancer on September 27, 2007. (Exhibit 3.)

16. On August 12, 2008 Respondent was asked to provide a current CV, along with a patient care summary, and certified medical records regarding Mrs. Aleman's care. On August 29, 2008 records were received from Respondent's attorney. The records contain ultrasound photos, a medication list, imaging reports labs tests, and consultation notes. (Exhibit 2.)

17. On October 20, 2009 Respondent came to the Sacramento district office of the California Medical Board for an interview. He was represented by his attorney. Also present at the interview were Dr. Vincent Yap, Medical Board District Medical Consultant, and Senior Investigator Anna Vanderveen. The interview was digitally recorded. (Exhibit 2.)

18. Respondent presented his CV and certificates of training for ultrasound technologists. Dr. Su is not board certified in any specialty although he states his training is in internal medicine and oncology. He does not have any hospital privileges.

19. He is not licensed in any other state, although he was licensed at one time in Massachusetts, Pennsylvania, Rhode Island and New York. Rhode Island disciplined his license after malpractice lawsuit and he surrendered his New York license after they took action against him based upon Rhode Island's action. He's been sued for malpractice twice, once in Rhode Island and in this case. (Exhibit 2.)

20. A transcript of Respondent's interview, along with all the medical records, charts, and films for patient Aleman were sent out for expert review to Dr. Craig Keenan, a board-certified specialist in internal medicine. On February 9, 2010 Dr. Keenan's expert report along with his curriculum vitae were received by the Board. Dr. Keenan found several extreme departures from the standard of care regarding Respondent's care and treatment of patient Aleman. (Exhibit 3.)

21. On February 9, 2010, the Board received an expert report from Dr. Kiran Jain, a specialist in radiology. Dr. Jain was asked to review the ultrasound images and the interpretation of those images made by Respondent. Dr. Jain reviewed the original images printed from the ultrasound machine by Respondent. She stated that the images were not properly labeled and did not even indicate right or left breast. As such, Dr. Jain stated that the images were grossly inadequate and completely nondiagnostic for interpretation of Mrs. Aleman's breast lump. Dr. Jain concluded the Respondent's treatment was an extreme departure from the standard of care and showed a complete lack of knowledge in performance and interpretation of breast ultrasound. (Exhibit 4.)

22. Dr. Vincent Yap reviewed the echocardiogram images taken of Mrs. Aleman by Respondent. Dr. Yap found that the images were of such poor quality that almost no cardiac structures were identifiable. The echocardiography images and Doppler signals were virtually useless and uninterpretable for clinical use in making an echocardiography diagnosis and clinical decision-making. The echocardiography measurements and report which presumably were obtained from these images were grossly erroneous. Dr. Yap concluded that the echocardiography study performed and interpreted by Respondent showed gross incompetence and lack of knowledge as an operator and interpreter of echocardiography. (Exhibit 5.)

23. As a result of the Board's investigation, and based on the expert review and opinion, Respondent's care and treatment of Mrs. Aleman was grossly negligent within the meaning of section 2234, subdivision (b) of the Code as follows:

a) Respondent's failure to notify the patient of abnormal mammogram results, failure to document the result of the mammogram and follow-up plan in the patient's chart, and failure to order appropriate follow-up studies, constitutes an extreme departure from the standard of care. (Exhibit 3.)

b) When R.A. reported a lump in her breast during her May 7, 2004 visit, Respondent's failure to perform a proper physical examination, including a thorough breast and lymph exam; his failure to refer Mrs. Aleman for a mammogram; and his reliance alone on the use of his ultrasound to diagnose the lump, constitutes an extreme departure from the standard of care. (Exhibit 3.)

c) Respondent performed and interpreted an echocardiogram on Mrs. Aleman without the appropriate training which is an extreme departure from the standard of care. (Exhibit 5.)

d) Respondent performed and evaluated several abdominal, pelvic and breast ultrasounds on Mrs. Aleman without the appropriate training which constitutes an extreme departure from the standard of care. (Exhibit 4.)

e) Respondent's record keeping and patient charting is so insufficient that it constitutes an extreme departure from the standard of care. (Exhibit 3.)

f) Respondent's performance and interpretation of ultrasound and echocardiograms on patient Mrs. Aleman were so lacking in detail and accuracy as to indicate respondent's lack of knowledge and training in the proper use of these diagnostic procedures which constitutes incompetence. (Exhibits 3, 4, and 5.)

24. Accusation No. 02-2008-193016 was filed against Respondent on July 1, 2010 based on his care and treatment of Mrs. Aleman. (Exhibit 6.)

//////

//////

//////

//////

SECOND CAUSE FOR ISSUANCE OF AN INTERIM SUSPENSION ORDER

(Gross Negligence)
[Bus. & Prof. Code § 2234(b)]

Patient Miller

25. On May 10, 2010 the Medical Board received two additional complaints regarding Respondent's care and treatment of two patients. Both of these complaints were filed by the Department of Social Services after conducting an investigation of Respondent's care and treatment of two patients who resided in a care home for the developmentally disabled. (Exhibit 2.)

26. The first patient, Mr. Miller, had an unobserved fall on May 27, 2009 in his residential care home. Mr. Miller suffered from cerebral palsy. On June 2, 2009 Mr. Miller was transported to the emergency room by the day program of his residential care home after it was observed that he was unable to move his fingers or lift his right arm. On June 3, 2009 Mr. Miller underwent surgery to repair a fractured right humerus which was completely displaced along with a severed bicep tendon. (Exhibit 2.)

27. The day before the hospitalization and emergency, Mr. Miller had been seen by Respondent on June 1, 2009 for right arm bruising and a swollen left hand. Respondent's treatment plan, according to the patient note, was to have a CT scan done of Mr. Miller's head, but Respondent did not address the chief complaint in his exam or treatment plan. (Exhibits 2 and 3.)

28. On July 22, 2010, Senior Investigator Vanderveen served a release for medical records on the UC Davis Medical Center and also on Dr. Su's medical office. On August 5, 2010 certified medical records were received from Respondent's office regarding Mr. Miller. (Exhibit 2.)

29. In Respondent's treatment notes for Mr. Miller, each visit contains the same identical vital signs for Mr. Miller in Respondent's assessment. Mr. Miller's blood pressure was always 120/80, his respirations were 24 per minute, his pulse was 80 beats per minute, and his weight was 194 pounds. For many visits, a medical assistant's chart notes indicated different vital signs along with a different chief complaint which did not always match the chief complaint and

Respondent's assessment. (Exhibits 2 and 3.)

30. In the June 1, 2009 the progress note prepared by medical assistant "SM", it lists Mr. Miller's vital signs and states the chief complaint was "cerebral palsy, left-hand swollen, bruising on right arm". Respondent's chart note did not mention the arm at all in the patient history and only stated "attendant noticed more fall lately". The vital signs were the same as for all his assessments and did not match what the medical assistant recorded on that day. The physical exam portion of Respondent's chart note was unchanged from the previous chart note and except for the addition of "penis; red swellin/diaper" from the note on April 3, 2009, the physical exam portion of his records is unchanged throughout his care of Mr. Miller. There is no notation of a physical exam of the arm and no notation of any bruising on Mr. Miller's body. (Exhibits 2 and 3.)

31. Respondent's notes for Mr. Miller were inaccurate in several other ways. For example, although Mr. Miller could only answer questions "yes" or "no", and needed assistance with most aspects of his daily care, including dressing himself, Respondent's chart notes for Mr. Miller state that he was not confused, was able to follow instructions, and was able to communicate. Respondent also stated that Mr. Miller was able to care for all of his personal needs, could administer his own medications, could feed, bathe and dress himself, and could leave the care home facility without assistance. Respondent's records also indicated that Mr. Miller was able to walk without assistance and could manage his own cash. Respondent's notes did not indicate Mr. Miller's cerebral palsy. (Exhibit 2.)

32. On September 14, 2010 Respondent came to the Sacramento District Office of the Medical Board for an interview. He was represented by his attorney. Also present for the interview was the District Medical Consultant, Dr. Vincent Yap and Senior Investigator Anna Vanderveen.

33. Respondent first saw Mr. Miller on July 16, 2008. That first appointment established him as Mr. Miller's primary care physician. Respondent was asked during the interview why several of his entries in the patient's charts from one visit to the next were identical including vital signs and the patient's weight. At that point Respondent terminated the interview. (Exhibit 2.)

34. The investigation report along with patient records and Respondent's interview pertaining to Mr. Miller was sent out for expert review. On September 7, 2010, Dr. Craig Keenan completed his expert review of this new complaint against Respondent. Dr. Keenan found several

extreme departures from the standard of care regarding Respondent's treatment of Mr. Miller. As a result of the Board's investigation, and based on the expert review and opinion, Respondent's care and treatment of Mr. Miller was grossly negligent within the meaning of section 2234, subdivision (b) of the Code in that he failed to conduct a proper history and physical for the patient, failed to address and treat the presenting medical issue, failed to order or conduct the necessary medical tests and examinations, and failed to adequately record treatment in the patient's chart. (Exhibits 2 and 3.)

THIRD CAUSE FOR ISSUANCE OF AN INTERIM SUSPENSION ORDER

(Gross Negligence)
[Bus. & Prof. Code § 2234(b)]

Patient Frizzell

35. On May 31, 2009 Mr. Frizzell had a witnessed fall at his care home for the developmentally disabled. Mr. Frizzell was capable of communicating and of caring for himself. He graduated high school and had attended some college. (Exhibit 2.)

36. On June 1, 2009 Mr. Frizzell was seen by Respondent at his office. Respondent's medical assistant noted that Mr. Frizzell complained of soreness to his side. Respondent did not address this complaint noted by his medical assistant either in his examination, or in the patient chart. Respondent's medical assistant, with the initials "S.U.", wrote that Dr. Frizzell stated he "fell and right side hurts". In contrast, the chart note done by Respondent dated June 1, 2009 shows Mr. Frizzell's history as being "fell and bruised left leg otherwise status quo". There is no record even indicating that Respondent examined Mr. Frizzell's right side where he had reported the pain to the medical assistant. (Exhibits 2 and 3.)

37. On June 6, 2009 Mr. Frizzell was found unresponsive on the bathroom floor of his care home. He was pronounced dead by emergency personnel. An autopsy found the cause of death to be right hemothorax due to blunt force thoracic injuries. (Exhibits 2 and 3.)

38. On September 14, 2010 Respondent came to the Sacramento District Office of the Medical Board for an interview. He was represented by his attorney. Also present for the interview was the District Medical Consultant, Dr. Vincent Yap and Senior Investigator Anna Vanderveen. However, Respondent terminated the interview without discussing his care and treatment of Mr. Frizzell. (Exhibit 2.)

39. The investigation report along with patient records and other material pertaining

to Mr. Frizzell was sent out for expert review. On September 7, 2010, Dr. Craig Keenan completed his expert review of this new complaint against Respondent. He found several extreme departures from the standard of care regarding Respondent's treatment of Mr. Frizzell. As a result of the Board's investigation, and based on the expert review and opinion, Respondent's care and treatment of Mr. Frizzell was grossly negligent within the meaning of section 2234, subdivision (b) of the Code in that he failed to conduct a proper history and physical for the patient, failed to address and treat the presenting medical issue, failed to order or conduct the necessary medical tests and examinations, and failed to adequately record treatment in the patient's chart. (Exhibit 3.)

FOURTH CAUSE FOR ISSUANCE OF AN INTERIM SUSPENSION ORDER

(Incompetence)
[Bus. & Prof. Code §2234(d)]

40. Petitioner incorporates paragraphs 7 through 39 as if set forth in full at this point.

41. Respondent is guilty of unprofessional conduct in violation of section 2234(d) of the Code in that his care and treatment of patients Aleman, Miller, and Frizzell constitutes incompetence, and is grounds for suspension and discipline as a violation of the Medical Practice Act.

Respondent Has Violated the Medical Practice Act and Permitting Him to Continue to Engage in the Practice of Medicine Will Endanger the Public Health, Safety, and Welfare

42. The facts and circumstances of this case have been reviewed and evaluated by three physicians with medical expertise their field. Dr. Yap, a cardiologist, found that Respondent's use of cardiography is so incompetent as to present a risk to the public for missed or erroneous diagnoses. Dr. Jain, board certified in radiology, found that Respondent's use of ultrasound was so incompetent that he presented a danger to the public from missed or erroneous diagnoses based on both results of the testing that was so bad it had no diagnostic use, and in using the technology when not medically indicated. Finally, Dr. Keenan reviewed all three cases and found that in all three, Respondent presents a threat to public safety by his demonstrated lack of knowledge and skill in the most basic of areas, such as proper evaluation of complaints and inappropriate diagnoses. (Exhibits 3, 4, and 5.)

43. In Dr. Keenan's opinion, Respondent is not presently fit to engage in the practice of medicine. His actions as set forth in the instant Petition and accompanying documents constitute multiple violations of the Medical Practice Act. Dr. Keenan believes Respondent demonstrates a profound lack of knowledge, medical judgment, and a disregard for the safety and well-being of his patients. (Exhibit 3.)

44. Dr. Keenan believes that permitting Respondent to continue practicing medicine at this time represents a threat to the public health, safety, and welfare. (Exhibit 3.) According to Dr. Keenan, Respondent medical license should be suspended immediately, before he causes serious injury to his patients. In his estimation, anything short of immediate suspension will result in serious injury to the public. Every patient Respondent treats is at risk of grave injury, or even death because of Respondents medical incompetence or lack of medical knowledge. (Exhibit 3.)

IV

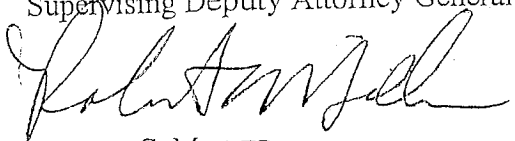
PRAYER

WHEREFORE, Petitioner prays that the Office of Administrative Hearings issue an *ex parte* interim order suspending Respondent's medical license until such time as this matter can be heard on regular notice pursuant to the provisions of California Government Code section 11529(c). Petitioner also prays that the Office of Administrative Hearings shall order such other and further relief as may be deemed appropriate to protect the public health, safety, and welfare.

Dated: November 2, 2010

EDMUND G. BROWN JR.
Attorney General of California

GAIL M. HEPPELL
Supervising Deputy Attorney General



ROBERT C. MILLER
Deputy Attorney General
Attorneys for Respondent