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

In the Matter of the Accusation Against: SUNIL PATEL, M.D.
9985 Sierra Avenue
Fontana, CA 92335

Physician’s and Surgeon’s Certificate
No. A 52005

Respondent.

Case No. 09-2002-135285
OAH No. L2004040660

DECISION PURSUANT TO STIPULATION


Richard D. Hendlin, Deputy Attorney General, represented complainant.

Paul Spackman, Attorney at Law, represented respondent.

The matter was submitted on July 22, 2005.

The administrative law judge issued a Proposed Decision on August 5, 2005, which was received by the Medical Board of California ("Board"). By letter dated January 9, 2006, respondent was notified by the Board’s Probation Unit that the decision had become effective by operation of law on November 8, 2005.

On December 5, 2005, respondent filed a Petition for Writ of Mandate in the Sacramento County Superior Court challenging the Board’s decision. (Patel v. Medical Board of California, Sacramento Superior Court Case No. 05CS01684.) The parties entered into a stipulation to remand the matter to the Board for further consideration. Pursuant to the Stipulation For Remand And Order signed by the Sacramento Superior Court on February 16, 2006, a copy of which is attached as Exhibit “A,” the Board hereby modifies the Decision that became effective by operation of law on November 8, 2005, and issues this superceding Decision Pursuant to Stipulation.
FACTUAL FINDINGS

Jurisdiction


The second amended accusation alleges respondent committed gross negligence, repeated negligent acts, and was incompetent in his care and treatment of three patients between 1998 and 2001. The second amended accusation also alleges respondent failed to maintain adequate and accurate records, knowingly made false documents, was dishonest, and committed general unprofessional conduct in connection with his treatment of these three patients.

2. On June 7, 1993, the Board issued Physician's and Surgeon's certificate No. A 52005 to respondent.

Respondent's Background

3. Respondent is 44 years of age. He attended college and medical school in India, graduating from the South Gujarat University/Government Medical College in Surat in January 1985. After completing an internship in 1986, he came to the United States. He did a residency in pediatric pathology at the Harvard Medical School/Children's Hospital in Boston and a three-year residency in internal medicine at the Northshore Medical Center in Salem, Massachusetts. He then did a fellowship in hematology/oncology at the City of Hope Medical School and Harbor-UCLA Medical Center for two years. He became board-certified in internal medicine in 1993 or 1994 and in oncology in 1995; he was recertified in both fields in 2003.

Respondent began working for Arizona Oncology Associates in Yuma, Arizona, in 1995. He returned to California in 1997 and worked for Inland Hematology/Oncology Medical Group in San Bernardino for one year, and in October 1998, joined Kaiser Permanente and worked at the Medical Center in Fontana. He is presently in charge of the hematology/oncology department and had been a member of the cancer and transfusion committees.

Lois M.

4. On September 24, 1998, Lois M., then age 71, underwent a CT scan at Kaiser Permanente Fontana Medical Center (Kaiser Fontana). It revealed extensive periaortic masses extending into the pelvis on both sides, with the findings suggestive of lymphoma. A small right pleural effusion was also seen. Lois M. then underwent a needle biopsy. Dr. Sung Shin diagnosed malignant lymphoma, B-cell type, and "morphologic and immunologic
features consistent with follicular lymphoma, small cleaved-cell type.” In the comment section of his report, Dr. Shin wrote:

The morphologic and flow cytometric findings indicate the presence of B-cell malignant. Even though follicular architecture is not seen in this needle biopsy specimen, the features are most consistent with follicular lymphoma of small cleaved cell type. For accurate subclassification of this lymphoma, an open biopsy of the lymph node is suggested.

On October 5, 1998, Lois M. underwent an excisional biopsy of two lymph nodes from the left groin.

5. Respondent first saw Lois M. on October 9, 1998 and prepared two short handwritten notes and a longer consultation report. In one of his handwritten note, respondent indicated his impression was “follicular small cleaved NHL [non-Hodgkins lymphoma], S/P [status post] excisional biopsy.” He did not know the stage since the staging work was still in progress. In the other note, respondent wrote his impression was a low grade NHL (follicular small cleaved cell).”

In the consultation report, respondent wrote the needle biopsy revealed findings consistent with low-grade lymphoma and the morphologic and immunologic features most consistent with follicular lymphoma, small cleaved cell type. His impression was “A 71-year-old female with a history of diet controlled diabetes and hypertension now recently diagnosed with follicular low grade small clear (sic) lymphoma.” In several other places in the note, respondent indicated the patient had a low grade follicular small cleaved cell type lymphoma.

Respondent’s plan was to treat Lois M. with Fludarabine chemotherapy. She received four cycles of Fludarabine, 50 mg. I.V. given daily for five days of each cycle starting on October 12, November 16, December 21, 1998, and January 22, 1999. On the third cycle, Lois M. received four days of chemotherapy instead of five.

6. The excisional biopsy of October 5, 1998 was analyzed by two pathologists. Dr. F. Azizi at Kaiser Fontana dictated a report in which his final diagnosis was “Malignant lymphoma, mixed small and large cell, diffuse (see BT report). It appears the report was typed on October 16, 1998. This would be interpreted as an intermediate grade malignant lymphoma.

Dr. Antonio Hernandez, a hematology pathologist from the Kaiser Medical Center in Los Angeles, analyzed the same specimen. His final diagnosis was:

1. Intermediate grade-malignant lymphoma, diffuse mixed small and large cell type, focally follicular (International Working Formulation)

2. Malignant lymphoma, mixed small and large cell, diffuse (Rappaport Classification)
3. Immunologic characterization on paraffin and frozen sections: positive for CD19, CD20, CALLA, and BCL-2 (B-cells).

Dr. Hernandez described his microscopic findings. Among other findings, he indicated "the pattern is diffuse with many small and moderately irregular lymphocytes with clearish cytoplasm admixed with scattered medium and large transformed cells (about 10%)." In a Note, Dr. Hernandez wrote "The findings are not inconsistent with follicular center cell origin."

7. Respondent next saw Lois M. on October 12, 1998 when she began her chemotherapy and had a bone marrow biopsy.

8. On October 26, 1998, a CT scan of the chest was performed and it revealed a moderate right pleural effusion. On November 26, following her second cycle of chemotherapy, blood tests revealed an elevated glucose of 339, an elevated creatinine of 1.5, and an elevated BUN of 30.

9. Respondent next saw Lois M. on November 9, 1998. His diagnosis remained "low grade NHL." Her lab results were low and he withheld chemotherapy for a week. On November 16, when respondent saw the patient, his diagnosis remained low grade NHL. He resumed chemotherapy. On December 21, 1998, respondent saw Lois M. and his diagnosis remained low grade NHL. She received her third cycle of chemotherapy. On January 18, 1999, respondent withheld chemotherapy because of a low white blood count. His diagnosis remained low grade NHL. Respondent saw Lois M. again on January 25 and resumed chemotherapy. Her diagnosis remained low grade NHL. Respondent withheld chemotherapy on February 22, 1999 because of a low white blood count and the patient was suffering from sinusitis. Her diagnosis remained low grade NHL. On March 25, 1999, respondent saw the patient and his diagnosis remained low grade NHL. His plan was to observe her. The patient’s next visit to respondent was on April 22, 1999, at which time his plan was to continue to observe her, and follow-up in two months. He wrote the diagnosis was "low grade NHL (follicular small cleaved cell)." Respondent’s chart note of June 22 was similar to the April 22 note.

10. On August 6, 1999, respondent discovered a 5 x 4 cm. mass in Lois M.’s left groin, associated with swelling of the left extremity. His diagnosis was “recurrent low grade NHL with left inguinal adenopathy and lower left extremity swelling.” He decided to repeat the staging evaluation and start chemotherapy with the CVP regimen. This consisted of cycles of cytoxan and vincristine to be given intravenously, and prednisone to be given orally for five days starting on the first day. Respondent wrote in his chart "prednisone 100 mg/d x 5d." He gave her a prescription for prednisone, 50 mg., ten pills, with one pill to be taken twice a day by mouth with meals for five days, with six refills. The cycle was to start on August 9. Respondent ordered CT scans to be performed as part of the re-staging evaluation but Lois M. did not keep the appointment. Respondent did not set up another appointment for re-staging purposes.
11. Lois M. began her first cycle of intravenous CVP chemotherapy on August 9, 1999, receiving cytoxan 1600 mg. and vincristine 2 mg. Lois M. started taking the prednisone orally on August 6 through August 9. On August 9, Sherry M., Lois M.'s daughter, spoke briefly with respondent and then refilled the prednisone prescription. She received two bottles of prednisone, each containing ten pills. Lois M. continued to take two prednisone pills daily until August 27.

Respondent next saw Lois M. on August 20. Her lymph node had significantly improved and he planned to follow-up on August 27, and he ordered blood tests. His diagnosis remained low grade NHL.

The results of the blood work as of August 21 showed abnormal BUN and creatinine levels.

12. After Lois M. began taking the prednisone on a daily basis, her condition began to change. She became forgetful and lethargic, she lost her appetite, she would become irate, loud, and impatient, her handwriting changed and became sloppy, and she became too weak to walk.

13. Lois M. returned to Kaiser for her second cycle of chemotherapy on August 27, 1999. She was in a wheelchair and was accompanied by Sherry M. After Lois M. received her chemotherapy and had blood drawn, she saw respondent. She complained of confusion. Sherry M. asked respondent what was wrong with her mother, and mentioned the pills. Respondent asked what pills. Sherry M. said Lois M. had been taking prednisone, 100 mg. a day, continuously for 20 days. Respondent said she was supposed to take it for five days. Sherry M. showed him the pill bottle. Respondent looked at the bottle and scolded Lois M. for taking the pills. Lois M. at that time was confused, disoriented, and her head was slumped as she sat in the wheelchair. Respondent told her to discontinue the prednisone and withheld the chemotherapy. Respondent wanted her to return on September 3. He did not give Sherry M. any instructions regarding her mother's diabetes and did not tell her anything about the side effects from taking an excessive amount of prednisone.

The CBC performed that day showed an elevated white blood count with most of the cells being granulocytes at 96.1 percent, and elevated creatinine and BUN levels.

14. On September 1, 1999, Lois M. was seen at the emergency room at Kaiser with decreased appetite, weakness, some questionable altered mental status, and polydipsia. Blood tests showed a significantly increased level of glucose. Among the impressions was diabetic ketoacidosis secondary to the lymphoma therapy, and the doctor planned to rule out sepsis and pneumonia. A chest x-ray revealed a cavitary infiltrate which was determined to be Aspergillus, a rare form of fungus. She received aggressive treatment. However, on September 18, 1999, Lois M. died. The cause of death was deemed to be multi-organ failure due to Aspergillus pneumonia with abscess, inadvertent prolonged use of prednisone, and NHL. Contributing causes were diabetes mellitus and hypertensive cardiovascular disease.
15. On December 1, 1997, William E., a 72-year-old man, underwent a right thoracoscopy with biopsy to a posterior thoracic mass, and on December 3, respondent performed a bone marrow biopsy. The biopsy of the thoracic mass revealed a malignant lymphoma, B-cell type, intermediate grade composite, follicular predominantly large cell and marginal zone type. The bone marrow biopsy revealed no evidence of lymphoma.

16. Respondent saw William E. on December 2, 1997. His plan was to await the final pathologic reports before deciding on treatment. On December 15, 1997, respondent saw William E. at his office at the Inland Hematology Oncology Medical Group. Respondent’s diagnosis was intermediate grade NHL and after discussion with the patient and his family, William E. would be scheduled for chemotherapy. The regime was to be CHOP, which consisted of cytoxan, adriamycin, vincristine, and prednisone. Respondent planned six cycles of chemotherapy and based on his current performance status, respondent was to decrease the dose of cytoxan and adriamycin by 20 percent. The patient’s vital signs were normal; his blood pressure was 141/88.

17. William E. received his first cycle of chemotherapy on December 19, 1997. Respondent saw him that day. He received three more cycles of therapy beginning on January 19, February 9, and March 2, 1998.

18. On March 14, 1998, William E. was hospitalized at the St. Bernardine Medical Center in San Bernardino with chief complaints of shortness of breath, left hip pain, and a high temperature. The assessment listed neutropenia (abnormally small numbers of neutrophils well below 500), more than likely the result of his chemotherapy. A CT scan taken while he was in the hospital revealed the tumors had resolved. He was treated for the neutropenia and anemia.

On March 18, 1998, while William E. was still at St. Bernardine, he fell and fractured his right hip fracture. A hemiarthroplasty of the right hip was performed; he tolerated the procedure well. He needed maximal assistance with physical therapy and arrangements were made for further rehabilitation at Shea Convalescent Hospital. He was discharged to Shea on March 21. He remained at Shea until he was transferred to Waterman Convalescent Hospital on March 30.

19. Respondent saw William E. on April 10 at his office. Respondent charted that William E. was currently at Waterman and was receiving physical therapy, and he complained of shortness of breath on exertion. Respondent wrote the patient “has had near complete response from the chemotherapy at this time.” Respondent decided to hold off his additional two cycles of CHOP chemotherapy; he noted William E.’s performance status had decreased. Respondent wrote he would hold chemotherapy until William E.’s performance status had improved.

20. William E. returned to respondent’s office on May 8, 1998. Respondent noted William E. was in a wheelchair and he complained of pain in the left leg. Respondent
indicated the patient’s NHL after four cycles of chemotherapy had “complete response.” Respondent decided to “hold off his chemotherapy for an additional two weeks for better improvement in his performance status.”

Respondent next saw William E. on May 22. The patient complained of cough with sputum production, and he was still wheelchair bound. Respondent noted there was no improvement in his performance status after rehabilitation. Respondent again decided to withhold chemotherapy due to his cough with sputum production.

21. On May 29, 1998, William E. returned to respondent’s office. Respondent noted there was no cough or sputum production and no shortness of breath. Respondent described the NHL as “in complete remission.” Respondent decided to give William E. two additional cycles of CHOP chemotherapy, explaining there had been a delay due to the hip fracture. Respondent discontinued the prednisone. He ordered follow-up in ten days with a CBC and platelets. His white blood count that day was 8,400 and his blood pressure was 90/71. William E. received his fifth cycle of chemotherapy that day. On June 12, the white count was 4,800 and his blood pressure was 90/71.

22. William E. received his sixth cycle of chemotherapy on June 19, 1998. Respondent charted the patient complained of a dry cough but no fever, chills, shortness of breath, chest pains, or palpitations. His temperature was normal and his blood pressure was 98/73. His white blood count was 20,700. Respondent gave William E. Cipro 500 mg. for the dry cough, and ordered a CBC with platelets.

William E. did not return for his next appointment with respondent on June 26.

23. On June 30, 1998, William E. was hospitalized with shortness of breath. His creatinine was high and his white blood count was very low. Blood cultures showed the presence of e.coli. William E. was treated aggressively, but he died on July 1.

24. June D. was William E.’s daughter and visited William E. daily while he was at Waterman. During that time, she never saw her father walk, and he was in bed 100 percent of the time during May and June 1998. William E. needed help going to the bathroom, he could not groom himself, his appetite was poor, and walking was painful. William E. was transported to respondent’s office in April, May, and June 1998 by wheelchair van.

Based on her observation of her father’s ability to ambulate, she believed it declined from May 29 to June 19. William E.’s energy level appeared to get worse.

25. The Waterman Convalescent Hospital records for the period of March 30 to June 30 were introduced into evidence. However, respondent never reviewed them and did not base his decisions regarding William E.’s performance status on any information contained within those records.
Dorothy D.

26. On February 15, 1998, Dorothy D., a 56-year-old female, went to the Urgent Care Unit of Kaiser Fontana with, among other things, occult blood, a markedly reduced hemoglobin, and asthmatic bronchitis. Further testing revealed a decreased serum iron level. A surgical consultation was conducted to evaluate her gastrointestinal (GI) bleeding and for other reasons. Dorothy D. was started on oral iron therapy for her anemia. While in the hospital, Dorothy D. refused an endoscopy but she did undergo a single contrast barium enema and a sigmoidoscopy. On February 23, Dorothy D. was seen because of three separate episodes of melena (dark colored, tarry stools due to the presence of blood) and bright red blood per rectum associated with some diarrhea. On February 24, it was suspected the dark stools were secondary to iron intake. On March 26, she was seen after having been transfused with blood in the hospital and on April 30, she complained of “dark jelly” stools on three occasions. Her hemoglobin was low and she was advised to restart the oral iron. She was scheduled for an upper GI x-ray. On May 4, Dr. Roger, her primary care physician, diagnosed Dorothy D. with anemia, anxiety, and non-compliance. On June 8, she was thought to have anemia secondary to hemorrhoids but on September 27, anoscopy was negative, but her stool was positive for occult blood. Her stool revealed occult blood on February 9, 1999 and on July 19, Dr. Roger indicated Dorothy D. had multiple questions about “diverticular bleed.”

Dr. James Morgenstern, an internal medicine physician, became Dorothy D.’s primary care physician and saw her on October 13, 1999. He noted she had chronic iron deficiency anemia. On December 2, Dr. Morgenstern’s impression was “worsening anemia,” probably from a GI source. He noted she had had an incomplete GI workup consisting of a single contrast barium enema and a flexible sigmoidoscopy in 1998. He indicated he planned to put in a referral to gastroenterology and she needed to be transfused. He also indicated he was going to ask Hematology to see if the patient needed to be considered for alternative iron supplementation such as intravenously if she has recurrent anemia that is not responding to oral iron. On December 13, Dr. Morgenstern placed a requisition for a colonoscopy to rule out a colonic source for the documented iron deficiency anemia. It was received in gastroenterology the next day.

27. Respondent performed a hematology/oncology consultation examination of Dorothy D. on January 5, 2000 due to her iron deficiency anemia. Respondent noted the previous tests and indicated she was awaiting a colonoscopy. He found her hemoglobin was low. Respondent’s impression was progressive anemia with the microcytic indices consistent with iron deficiency anemia. He questioned whether there was a GI blood loss or poor absorption of iron. He discussed with the patient that she had had no improvement in her hemoglobin despite the iron supplement and they would consider IV iron 500 mg. daily for three days. He further indicated that if she had a negative colonoscopy evaluation, she may require either a urologic or gynecologic evaluation to rule out other causes of blood loss. Finally, he indicated if other workups are non-diagnostic, parenteral iron therapy would be continued.
28. Respondent had Dorothy D. begin receiving iron dextran IV on January 12, 2000. She first received a test dose of 25 mg. and then received another 475 mg., for a total dose of 500 mg. Respondent also had iron dextran IV administered on March 6 in a similar fashion, and again on March 13.

29. On January 17, three stool samples were positive for occult blood. Dorothy D. was seen on January 26 for dizziness, night sweats and fever, and anemia. Dr. Houssiere saw her that day and his impression was probable recurrence of iron deficiency anemia from GI bleeding, probably lower GI.

30. Respondent saw Dorothy D. on February 2, 2002 and he again questioned whether she had a GI bleed and stated he was awaiting a colonoscopic evaluation. Respondent saw her again on March 1 for follow-up of iron deficiency anemia and she was still awaiting colonoscopy. Dr. Morgenstern also indicated that day her chronic anemia was not getting better, and on March 24, he noted Dorothy D. had received blood transfusions, she felt fatigued, and he was awaiting colonoscopy. On April 19, 2000, respondent saw Dorothy D. and noted the iron deficiency anemia, she was still awaiting a GI workup, and she would be given oral iron. Again, on May 17, respondent saw Dorothy D. for iron deficiency anemia and ordered iron studies. On June 14, respondent saw Dorothy D. for iron deficiency anemia and noted she was awaiting a GI evaluation. The patient had a low hemoglobin and his plan was to admit her to the Adult Holding Unit for a transfusion and GI evaluation. An upper endoscopy performed on June 15 and a sigmoidoscopy were negative. Her hemoglobin on July 21 was low and she received blood transfusions. The patient cancelled her colonoscopy scheduled for July 28 and on August 8, she received blood transfusions in anticipation of colonoscopy.

31. On August 18, 2000, a colonoscopy was performed on Dorothy D. It was negative.

32. Respondent next saw Dorothy D. on August 21 and his diagnosis included iron deficiency anemia and he questioned the source. He planned to give her oral iron and would schedule her for IV iron.

33. Dr. Morgenstern saw Dorothy D. on August 28 and considered getting a small bowel series. On September 13, her iron was abnormally low.

34. On October 30, 2000, respondent saw Dorothy D. who questioned occult GI bleeding and planned to give her IV iron. He noted she reported melena.

35. On January 28, 2001, Dorothy D.'s hemoglobin was low and she was scheduled for blood transfusions. On January 24, she had rectal bleeding with blood mixed with stools. Her hemoglobin was low and her alkaline phosphatase was increased. She was seen in the emergency room for rectal bleeding.
36. On February 16, 2001, respondent again saw Dorothy D. for iron deficiency anemia and he advised IV iron daily for three days. On March 16, respondent ordered IV iron therapy for three days.

37. Dr. Morgenstern ordered a CT scan on the abnormally elevated alkaline phosphatase and it showed a colonic mass in the ascending/hepatic flexure and a three centimeter cyst in the liver. On June 11, a colonoscopy revealed a large, ulcerated mass in the hepatic flexure. On July 17, a right hemicolectomy and cholecystectomy was performed and pathology revealed a moderately differentiated colonic adenocarcinoma with invasion of the ileum. The tumor was 13.5 cm by 8.5 cm and it extended into the entire thickness of the wall to the pericolic adipose tissue. On August 13, 2001, respondent noted Dorothy D. had Duke C, Stage III, T4 N1 Mo colon cancer. Her hemoglobin had improved. The patient received chemotherapy and her anemia subsided after her hemicolecetomy.

Expert Witnesses


Incompetence is distinguished from negligence in that one may be competent or capable of performing a given duty, but negligent in performing that duty. A single act of negligence is not equivalent to incompetence. While a single negligent act under certain circumstances may reveal a general lack of ability to perform licensed duties, thereby supporting a finding of incompetence, a single honest failing in performing those duties, without more, does not constitute a finding of incompetence justifying sanctions. See Kearl v. Board of Medical Quality Assurance (1986) 189 Cal.App.3d 1040.

It is incumbent upon the trier of fact to determine the standard of professional learning, skill and care required of respondent only from the opinions of the physicians, including respondent, who have testified as expert witnesses as to such standard. The trier of fact must consider each such opinion and should weigh the qualifications of the witness and the reasons given for his or her opinion. The trier of fact must give each opinion the weight to which it deems it entitled.

39. Dr. Jacques V. Souadjian was complainant's expert witness. He attended the American University of Beirut, Lebanon and Oxford University in England before beginning medical school at the University of Ottawa. He graduated in 1963 and after a one-year rotating internship, was a fellow in internal medicine at the Mayo Clinic for three years, and then was a fellow in hematology and oncology at the Mayo Clinic. He is board certified in
internal medicine and board certified in hematology in Canada. He is not board certified in the United States in hematology and oncology because those boards did not exist at the time he completed his training.

Dr. Souadjian began his teaching career in 1969 when he became an assistant professor in the Department of Medicine, Hematology Section, at the University of Sherbrooke, Quebec, Canada. He returned to the United States in 1972 and became an assistant adjunct professor at UCI. He also became a consultant and partner in a medical group in Orange County in the field of hematology and oncology, and remained in that position for 24 years. He continued to teach at UCI and is presently a clinical professor of medicine at UCI in the hematology/oncology section. Over the years, among other things, Dr. Souadjian has served on cancer committees and other committees at St. Joseph’s Hospital in Orange, was the founder and chairman of the Tumor Board at St. Joseph’s, served as the president of the Society of Hematology and Oncology of Orange County, served as a director of the Oncology Unit of Chapman General Hospital, served on a medical ethics review and advisory committee, was the managing editor of the Journal of Infusional Chemotherapy, was a member of the Board of Directors of the American Cancer Society (California Division), and was a district medical consultant for the Board. Since 1997, he has provided consultations and second opinions in the field of internal medicine, hematology, and oncology. He has performed forensic legal work for 35 years and reviewed cases on behalf of plaintiffs and defendants. He has made numerous presentations at professional meetings, has had 37 articles published, and co-authored a book relating to continuous infusional chemotherapy.

Dr. Souadjian was well-qualified to render opinions on the standard of care as it related to respondent’s care and treatment of Lois M., William E., and Dorothy D.

40. Dr. Aziz-Ur-Rehman Khan was respondent’s primary expert witness on the standard of care issues. Dr. Khan attended Forman Christian College in Pakistan for two years and then attended Allama Iqbal Medical College in Lahore, Pakistan for seven years, receiving an MBBS degree in 1982. After doing a one-year internship in internal medicine at the Services Hospital at Punjab University in Lahore, Dr. Khan came to the United States in 1985 and did an internship at the General Hospital at Georgetown University, followed by a two-year residency there. Dr. Khan then did a two-year fellowship at the Los Angeles County-USC Medical Center in medical oncology, and a one-year fellowship there in hematology. Dr. Khan became licensed in California in 1988 and is board certified in internal medicine and medicine oncology. In addition, he supervises the lymphoma/leukemia clinic at the Los Angeles County-USC Medical Center and treats patients at the Norris Cancer Center about six months a year.

Dr. Khan became an assistant professor of clinical medicine at the USC Keck School of Medicine in July 1991, and in 2000 became as associate professor of clinical medicine. He has conducted research in bone marrow transplants and hematological malignancies, and has written a number of peer-reviewed manuscripts and abstracts.
Dr. Khan was well-qualified to render opinions on the standard of care as it related to respondent’s care and treatment of Lois M., William E., and Dorothy D.

41. Dr. Soudajian testified respondent’s care and treatment fell below the standard of care in a number of respects in connection with his care and treatment of Lois M., William E., and Dorothy D. Dr. Khan testified respondent’s care and treatment of those patients did not fall below the standard of care. Both witnesses are equally well-qualified to render opinions on the care and treatment of patients suffering from lymphoma and iron deficiency, although Dr. Soudajian had somewhat more experience than did Dr. Khan. The difference in experience, however, is not by itself sufficient to determine that Dr. Soudajian’s testimony is entitled to greater weight than Dr. Khan’s.

What is significant and determinative, however, is the relative objectivity of Dr. Soudajian and Dr. Khan, and there was a considerable difference. That difference appeared most evidently in their analyses of the issue relating to the diagnosis of Lois M. Respondent began treating Lois M. after he had received the results of the needle biopsy but before he had received the results of the excisional biopsy. According to Dr. Soudajian, that was below the standard of care. He gave respondent the benefit of the doubt by concluding respondent’s mistake was an innocent one, in that respondent did not have the result of the excisional biopsy and should have waited until he received it. However, respondent testified at the hearing that he received the result of the excisional biopsy and even spoke to Dr. Hernandez who did not change his diagnosis, and yet in his opinion Lois M. suffered from a low grade lymphoma. Based on that additional piece of evidence, Dr. Soudajian testified on rebuttal that he believed respondent’s departure from the standard of care was an extreme one, and could no longer be characterized as innocent. He reasoned that respondent should have accepted the opinion of the pathologist on the grade of the lymphoma, and if he did not, he should have viewed the slides himself or requested another opinion, stopped treatment until the grade could be determined, and documented all that in the chart. Respondent did none of this. Dr. Soudajian’s reading of the medical record is a reasonable one, and his conclusions are compelled by the evidence contained in the medical records and respondent’s testimony. His testimony was objective, and it showed he was willing to give respondent the benefit of the doubt.

Dr. Khan testified respondent did not depart from the standard of care because he classified the lymphoma and treated Lois M. appropriately, based on a different and newer lymphoma classification system. Under this system, called the REAL (for Revised European-American Classification of Lymphoid Neoplasms) and established by the World Health Organization, the grade of lymphoma is determined by the cell of origin rather than the appearance of cells under the microscope. In his opinion, Dr. Hernandez’ findings and report showed the lymphoma to be a grade two lymphoma and was therefore an indolent one which could be treated in the same manner as a low grade lymphoma under the older system.

Neither Dr. Hernandez nor respondent used the REAL system for classifying lymphomas in 1998. Nor did Dr. Azizi. It is obvious from a reading of respondent’s medical records that he misdiagnosed Lois M.’s lymphoma as a low grade lymphoma based upon the needle biopsy, and nothing more. Respondent either did not read or simply ignored the two
pathology reports of the excisional biopsy, which came in after he began treatment, and which showed the lymphoma was an intermediate grade lymphoma. The only question is the degree of respondent’s mistake. Yet Dr. Khan defended the indefensible.

Furthermore, Dr. Soudajian, supported by authoritative texts, testified that under the REAL classification, the lymphoma described by Dr. Hernandez in his pathology report would be considered an aggressive lymphoma and treated with a combination of chemotherapy agents, rather than the one agent respondent used. The treatment under the REAL classification of an aggressive lymphoma would be the same as the treatment of an intermediate grade lymphoma under the International Working Formulation classification Dr. Hernandez used. Dr. Soudajian’s testimony on this point is more persuasive than Dr. Khan’s.

By trying to defend respondent’s misdiagnosis of Lois M. in the way he did — by referring to a classification system that was not in use at Kaiser Permanente in 1998, by not candidly saying that under the REAL system of classifying lymphomas, respondent’s treatment was still incorrect, and by failing to acknowledge that respondent never considered the possibility that Lois M. was suffering from an intermediate grade lymphoma — Dr. Khan showed he was not objectively viewing respondent’s care and treatment of the patient and instead was offering an ill-conceived and pre-conceived defense. Since his opinion on this subject cannot be trusted, his opinions on respondent’s care and treatment on other subjects similarly cannot be trusted.

42. Dr. Russell Yang practices gastroenterology and testified as an expert on that subject relating to respondent’s care and treatment of Dorothy D. After finishing college at Trinity College in Hartford, Connecticut, Dr. Yang received a master’s degree and a Ph. D from MIT in nutritional biochemistry and metabolism in 19872. He attended Baylor Medical School and did his internship and residency at Duke University in internal medicine. He then did a fellowship in gastroenterology, first at the University of Texas and then at the Los Angeles County- USC Medical Center. He is a full-time professor at the USC Keck School of Medicine and does clinical research in the field of gastroenterology. He is well-qualified to testify on the subject of gastroenterology.

43. Dr. Ernest Beutler testified for respondent on the issue of the propriety of using iron dextran to treat Dorothy D.’s iron deficiency anemia. Dr. Beutler viewed himself as a physician/scientist. He stopped seeing patients about six years ago. He is board certified in internal medicine and hematology, and has practiced medicine for more than 50 years. He is presently the Chairman of the Department of Molecular and Experimental Medicine at Scripps Research Institute in La Jolla and performs consultations for other physicians. His curriculum vitae lists 19 books, 778 journal articles, 274 chapters, 45 editorials, and 177 abstracts that he has written. Among the chapters he wrote was one in Williams Hematology, an authoritative text relating to iron deficiency, which other experts referred to during the course of their testimony. He has conducted research on iron deficiency and metabolism. Dr. Beutler was extremely well qualified to render opinions in his field of expertise.
Respondent’s Testimony Relating to Lois M.

44. Respondent testified at the hearing that he considered Lois M.’s lymphoma to be a low grade one and treated her accordingly with a single agent. He never changed his diagnosis. He testified he spoke to both Dr. Azizi and Dr. Hernandez during the second or third week of November 1998 about their excisional biopsy findings. According to respondent, Dr. Azizi told him he did gross cutting of the specimen and then sent it to a Kaiser hospital in Los Angeles, and when he spoke to Dr. Hernandez either the same or the next day, they compared the results of the needle biopsy with the results of the excisional biopsy, and they were comparable. Respondent testified Dr. Hernandez told him he would review the results of the needle biopsy, and after he did so, his findings would not change. Respondent testified he received a fax copy of Dr. Hernandez’ report which he had placed in the Kaiser Fontana medical chart.

45. Respondent did not document any discussion with Dr. Azizi or Dr. Hernandez in his chart. He did not make any notes of his conversations with them. Dr. Hernandez’ report was not contained within the original Kaiser Fontana chart. Respondent did not document his disagreement with Dr. Hernandez relating to the grade of the lymphoma, and acknowledged that the pathologist diagnosed the grade. He acknowledged he had an ethical and professional responsibility to accurately document the diagnosis and if he disagreed with the pathologist, to set forth his reasons. Respondent was interviewed by an investigator and consultant with the Board and never mentioned any discussion with Dr. Hernandez, nor did he mention it during his deposition taken in connection with a civil action brought against him. Respondent’s testimony that he had several conversations with Dr. Hernandez and Dr. Azizi and that Dr. Hernandez told him the results of the needle biopsy and the excisional biopsy were comparable when they plainly are not is not credible and is rejected.

Respondent’s Testimony Relating to Dorothy D.

46. Respondent testified that at the time he first examined Dorothy D., he knew Dr. Morgenstern had sent in a referral for a colonoscopy, and he told Dr. Morgenstern he would manage the patient’s anemia. He explained his reference to urologic and gynecologic workups was a recommendation to the primary care physician in case the Gl workup did not disclose the source of her bleeding, and he pointed to her history of heavy menses and hematuria. Respondent envisioned his role as a consultant helping the primary care physician manage the patient.

Respondent testified he discussed the benefits, risks, and side effects of IV iron with Dorothy D., she understood them, and agreed to the IV iron therapy. Respondent testified he used the medication cautiously, and he gave it to her before the colonoscopy was performed because she had had persistent anemia which was not improving with the oral iron and she

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1 Respondent later changed his testimony and said it was the responsibility of the oncologist to clarify a diagnosis made by a pathologist because it could be misleading, and he had a responsibility as the oncologist to make a clinical diagnosis of the grade. That testimony was contradicted by Dr. Souadjian.
had received transfusions. He felt the risk to the patient of transfusions was greater than giving her IV iron therapy.

Respondent testified he was becoming frustrated with the GI department because the colonoscopy was taking so long. He testified that every time he saw Dorothy D., either he or his nurse called the GI department to find out when the colonoscopy would be scheduled. Each time he called, he was told she was on the list and someone would triage her and she would be scheduled. When calling the GI department proved unsuccessful, respondent admitted Dorothy D. to the Adult Holding Unit when her hemoglobin was reported to be low, she was symptomatic from anemia, and was weak. He hoped the admission would result in a quicker GI workup and asked the GI department to rule out GI bleeding as a cause of her anemia. He wanted a workup that went beyond a colonoscopy and included the small bowel as well. A GI workup was done, but it did not include a colonoscopy, and it did not detect the cause of her bleeding.

Respondent testified Dorothy D. never experienced any adverse reactions from his administration of IV iron, and that each time she received the medication, her hemoglobin improved. He testified he did not ask for a second colonoscopy immediately after the first one because he had no reason to second guess the radiologist at that time.

Respondent explained he did not order tests such as vitamin B-12 and folic acid because they were not related to iron deficiency anemia. Rather, they concerned a different form of anemia.

Character Evidence

47. Dr. Craig Arakiki is a pulmonary critical care physician and works for Kaiser Fontana. He has practiced medicine for 20 years, and has known respondent for seven years. They work in the same building and there have been many occasions when they treated the same patient. On such occasions, they often discuss the patient. Based on his frequent contact with respondent, Dr. Arakiki testified he trusts what respondent says and seeks him out for advice. He believed respondent’s judgment was excellent and he was honest and very helpful. He testified everyone in the medical group respected respondent’s integrity and abilities. In addition, patients have expressed satisfaction to him about respondent’s care.

48. Respondent submitted a number of letters from other physicians and patients describing the high quality of care he provided to patients.

Costs

49. For the investigation and enforcement of this matter, the Board incurred Attorney General’s costs in the amount of $23,839.75, investigative services costs in the amount of $7,624.27, and expert reviewer costs in the amount of $6,985.00. The total is $38,449.02. The amount is reasonable.
LEGAL CONCLUSIONS

1. In this proceeding, complainant bears the burden of establishing the charges by clear and convincing evidence to a reasonable certainty. *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853. This requires the evidence to be "of such convincing force that it demonstrates, in contrast to the opposing evidence, a high probability of the truth" of the charges (BAJI 2.62), and to be "so clear as to leave no substantial doubt." *In re Angelia P.* (1981) 28 Cal. 3d 908, 919; *In re David C.* (1984) 152 Cal.App.3d 1189, 1208. If the totality of the evidence serves only to raise concern, suspicion, conjecture or speculation, the standard is not met.

2. The First Cause for Discipline of the Second Amended Accusation alleges respondent committed gross negligence and repeated negligent acts, and was incompetent in violation of Business and Professions Code section 2234, subdivisions (b), (c), and (d), in connection with his care and treatment of Lois M. in a number of respects. Based upon the determination that Dr. Soudajian's testimony was more persuasive and his opinions were more reasonable and objective than those of Dr. Khan (Factual Findings 39 and 41), it must be concluded respondent committed repeated acts of negligence, was grossly negligent, and incompetent as follows:

   A. It is alleged respondent misdiagnosed Lois M. as having follicular lymphoma, a low grade lymphoma, when in fact, she suffered from diffuse lymphoma, an intermediate grade lymphoma, and treated her inappropriately because of the misdiagnosis. Respondent's chart notes clearly show he made the diagnosis of a low grade follicular lymphoma on October 9 at a time when he had the results of the needle biopsy but not the results of the excisional biopsy. Although he knew on October 9 that an excisional biopsy had been done, his chart shows that on every visit thereafter, respondent never changed the diagnosis to an intermediate grade, diffuse mixed small and large cell, focally follicular, as found by Dr. Hernandez. There is nothing in the chart to suggest respondent appreciated Dr. Hernandez' report between the time of the first visit on October 9 and the conclusion of the four cycles of chemotherapy in January. The standard of care required him to consider the pathology report. His failure to do so violated the standard of care and was negligent.

   Respondent treated Lois M. based on his misdiagnosis of low grade lymphoma. The standard of care required him to take the results of the excisional biopsy into account in deciding on a treatment regime. Since he did not have the results on October 9, but knew an excisional biopsy had been done, he should have waited until he received the report before beginning treatment. His decision to proceed with treatment without the report of the excisional biopsy violated the standard of care and was negligent.

   Respondent treated Lois M. with a single agent chemotherapy, fludarabine, based on his misdiagnosis of a low grade lymphoma. This resulted in sub-optimal treatment. A more aggressive treatment regime was necessary to treat the patient's intermediate grade lymphoma, and that would have consisted of multiple chemotherapy agents. Respondent's decision to treat Lois M. only with fludarabine was a violation of the standard of care and was negligent.
B. It is alleged respondent failed to follow-up on the CT findings of pleural effusion. The CT scans of Lois M.'s chest were part of the staging evaluation. The first finding on September 24 was of a small right pleural effusion but on October 26, after the first cycle of chemotherapy had been administered, the finding was of a moderate pleural effusion. The standard of care required respondent to investigate the pleural effusion for the presence or absence of lymphoma in the pleura. Presence of lymphoma in the pleura could have changed the staging determination and could result in different treatment. Respondent did not consider the pleural effusion in staging of her disease. Respondent's failure to follow-up on the findings of pleural effusion was below the standard of care and was negligent.

C. It is alleged respondent failed to note on the August 6, 1999 prescription for prednisone that it was to be taken only for five days. The standard of care required him to both explain to the patient that she was to take the medication for five days and provide that information on the prescription. Because he did not do that, Lois M. took the medication for 20 consecutive days. Respondent's failure to write down on the prescription the number of days the patient was to take the prednisone was a departure from the standard of practice and was negligent.

D. It is alleged respondent failed to monitor the side effects of the prednisone on Lois M.'s diabetes. Respondent knew the patient suffered from diabetes and he should have been aware of her medical history relating to diabetes as shown in her chart. Prednisone can exacerbate diabetes. Among the concerns would have been increased hyperglycemia, psychosis, salt and water retention, and gastric acidity. The degree of the risk is determined by the severity of the diabetes and how well it was controlled. Respondent should have known the patient did not have a history of controlling her diabetes well. He should have obtained a blood sugar level but did not. Respondent's failure to monitor the side effects of the prednisone Lois M. was taking was below the standard of care and was negligent.

E. It is alleged respondent failed to evaluate Lois M. for her rising creatinine and BUN as well as her renal failure on August 20, 1999. Renal failure is a frequent complication from uncontrolled diabetes but respondent did not do anything. He should have considered the rising creatinine and BUN results but did not do so. This failure violated the standard of care and was negligent.

F. It is alleged that on August 27, 1999, respondent failed to obtain blood sugar and electrolytes levels. It was on that day that respondent learned Lois M. had been taking large doses of prednisone for twenty days instead of five. He knew she was a diabetic and it was not controlled. He knew she was confused and there was a change in the level of consciousness. He should have either obtained a blood sugar and electrolytes or alerted her primary care physician that Lois M. had been taking prednisone for twenty days. It was not enough for him to simply tell her to discontinue the prednisone and return in a week.

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Respondent’s failure to act appropriately between August 6 and August 27, as set forth above, was an extreme departure from the standard of care and was gross negligence.

G. Respondent’s failure to consider the final report of the excisional biopsy which caused him to treat Lois M. inappropriately, his failure to investigate the change in the patient’s pleural effusion, his failure to record on the prescription the number of days Lois M. was to take the prednisone, and his failure to take the appropriate steps between August 6 and August 27, 1999, demonstrated incompetence.

3. The Second Cause for Discipline of the Second Amended Accusation alleges respondent committed gross negligence and repeated negligent acts, and was incompetent in violation of Business and Professions Code section 2234, subdivisions (b), (c), and (d), in connection with his care and treatment of William E. Based upon the determination that Dr. Soudajain’s testimony was more persuasive and his opinions were more reasonable and objective than those of Dr. Khan (Factual Findings 39 and 41), it must be concluded that respondent committed repeated acts of negligence, as follows:

A. It is alleged respondent failed to withhold chemotherapy on May 29 1998 despite the fact there was no evidence William E.’s performance status had improved.

Respondent acted appropriately and within the standard of care when he withheld the fifth cycle of chemotherapy from William E. on April 10, May 8, and May 22, 1998. The patient was wheelchair-bound and his performance status was poor. He had undergone four cycles of chemotherapy and was weakened to the point where he had to be hospitalized for the side effects of chemotherapy. After he broke his hip and was recovering from that injury, and was still in a weakened condition, continued chemotherapy had the potential to be lethal. Chemotherapy is toxic, and while it is a life-saving procedure, the patient has to be strong enough to withstand it. However, William E. was not eating well, needed assistance with the activities of daily living, and was completely bedridden. His performance which caused respondent to appropriately withhold chemotherapy did not improve between May 22 and May 29 except his cough had improved.

The standard of practice required respondent to continue to withhold chemotherapy on William E. The patient was recovering from a hip fracture. The presence of a cough is a good reason to withhold chemotherapy since the cough could indicate a lung infection, but the absence of a cough is not an indication that performance has improved, particularly where the patient is bedridden. Chemotherapy had been withheld for about seven weeks and as of April 10, according to respondent, the patient had undergone near complete response. Rather than submit this weakened patient to another cycle of chemotherapy, respondent could have repeated some of the staging studies if he was concerned about whether the patient had a significant response. If those studies showed some evidence of lymphoma, that might have been a justification for continuing chemotherapy in spite of his poor performance status.
Respondent’s decision to administer the fifth cycle of chemotherapy to William E. on May 29, 1998 was below the standard of care and was negligent.

B. It is alleged respondent failed to withhold chemotherapy on June 19, 1998 despite the fact there was no evidence William E.’s performance status had improved, and he presented with evidence of dehydration.

The same considerations that required respondent to withhold chemotherapy on May 29 required him to withhold chemotherapy on June 19. The patient’s performance status had not improved. In fact, he was worse. He complained of a dry cough and his white count was elevated. It had never been elevated before. His blood pressure was relatively low, particularly for a patient suffering from hypertension. Given that the patient had already received five cycles of chemotherapy, respondent should have considered infection and dehydration. Based on these considerations, plus the fact that the patient’s performance status had not improved, respondent should have withheld chemotherapy. Respondent’s decision to administer the sixth cycle of chemotherapy to William E. on June 19, 1998 was below the standard of care and was negligent.

4. The Third Cause for Discipline of the Second Amended Accusation alleges respondent committed gross negligence and repeated negligent acts, and was incompetent in violation of Business and Professions Code section 2234, subdivisions (b), (c), and (d), in connection with his care and treatment of Dorothy D. in a number of respects. Because respondent relied to a substantial degree on the testimony of Dr. Yang and Dr. Beutler, a different analysis is required.

Respondent was only one of several physicians who undertook Dorothy D.’s care. Her primary care physician for the most part relevant to this case was Dr. Morgenstern. Respondent’s role was limited to the management of her iron deficiency anemia. By the time respondent entered the picture, Dr. Morgenstern had referred her to the GI department for a workup to determine the cause of her GI bleeding. Respondent, as a hematologist/oncologist, obviously had nothing to do with that aspect of her care.

Dorothy D. had a long-standing history of iron deficiency anemia. It was first documented in 1998, and she had received incomplete and ineffective workups. Thus, when respondent first saw her on January 5, 2000, she had already been referred to the GI department for a colonoscopy. According to Dr. Yang, a proper workup in 1998 or 1999 could have resulted in the discovery of the cancer, and he based that opinion on the size of the tumor when it was discovered and the relatively slow rate at which such tumors grow. In any event, by 2000, this patient, with her history, should have been given a high priority for a colonoscopy, and it was the responsibility of the GI department to do that. Both Dr. Yang and Dr. Beutler correctly criticized the GI department for failing to perform a colonoscopy in a timely fashion.

A. It is alleged respondent failed to establish whether Dorothy D. had a correctable disease process in her gastrointestinal tract which was causing her to have chronic iron deficiency anemia associated with bleeding from the GI tract prior to treating
her with IV iron therapy. In Dr. Soudajian’s opinion, there should have been a very clear indication for IV iron therapy because it is a more dangerous therapy than oral therapy. The primary concern was a severe anaphylactic reaction that can lead to respiratory arrest, and required that the medication be used with caution in patients with a history of significant allergies and/or asthma. Dr. Soudajian believed it was an extreme departure from the standard of care for respondent to begin IV iron therapy on Dorothy D. before determining the cause of the GI bleeding and determining if the cause was correctable.

Dr. Beutler testified that in 2000-02, iron dextran was the major drug used to treat iron deficiency anemia, but it carried risks such as transient fever and arthralgia as well as anaphylaxis which can cause death. He testified investigators had determined the risk of death to be 1.2 deaths per million dosages. However, he had not seen any reports of increased risk in patients with allergies and asthma. He did not believe a warning to this effect on a package insert was of much value in deciding whether the medication ought to be used.

In Dr. Beutler’s opinion, IV iron was a therapy regardless of whether the source was correctable. Dorothy D. needed iron dextran to treat her iron deficiency and that was the primary consideration from respondent’s point of view. His alternative was transfusions, but in Dr. Beutler’s opinion, transfusions posed greater risks and higher morbidity than IV iron. He believed it would have been inappropriate not to give the IV iron and subject the patient to transfusions, and it should have been given while the patient was being worked up to determine the cause of her bleeding. He reasoned that a doctor cannot withhold treatment if that endangered the patient.

Dr. Beutler’s opinion makes sense. The GI department had failed in two years to determine the cause of Dorothy D.’s bleeding and after receiving oral iron, Dorothy D. was still anemic. Respondent needed to do something, and he chose the best course available to him. In addition, he administered the IV iron cautiously and in accordance with the suggested method of administering the medication, with a small test dose given first, followed by the balance of the medication if the test was successful, and it was administered in a hospital setting.

It cannot be concluded that respondent departed from the standard of care when he administered IV iron to Dorothy D. before the cause of her GI bleeding had been determined.

B. It is alleged respondent failed to document that Dorothy D. was informed about the possibility that her asthma might be dangerously exacerbated with IV iron therapy. According to Dr. Beutler, he had not seen anything in the literature that indicated there were increased risks to patients with asthma who received IV iron dextran, and he had never heard such a claim from any of his colleagues. Dr. Beutler’s knowledge about such matters in this field is truly impressive, and it is appropriate to rely on his views. Accordingly, respondent did not depart from the standard of care regarding any warning about the dangers associated with IV iron therapy to a patient with asthma.
C. It is alleged respondent failed to document that he made sufficient attempts to expedite the colonoscopy by explaining the reasons for the urgency and failed to request a formal GI consultation when it became apparent the colonoscopy was being delayed for months. There can be no question that Dorothy D. deserved to have a colonoscopy performed and it should have been done immediately after Dr. Morgenstern sent the referral to the GI department in December 1999. Respondent as the hematologist managing the patient’s iron deficiency anemia did not have the responsibility of determining the cause of the bleeding. The issue is whether the GI department’s failure to perform the colonoscopy in a timely fashion should be attributed in some way to respondent.

The issue raises the question of how medical care is organized. The overall care of Dorothy D. fell on Dr. Morgenstern as her primary care physician, and part of that care required him to refer the patient for a GI workup and then expedite the workup in light of her symptoms. The testimony of Dr. Beutler, Dr. Yang, and Dr. Khan make it clear that respondent’s role as a consultant managing the patient’s iron deficiency anemia did not include pushing the GI department to do the appropriate workup. Their testimony is reasonable and makes sense. Nevertheless, after several months of waiting, respondent did take a step toward having her worked up by having her admitted to the Adult Holding Unit. Yet that effort failed as well. Under these circumstances, it is unfair to hold respondent responsible for the failure of the GI department to perform its job. Respondent therefore did not depart from the standard of care.

D. It is alleged respondent failed to consider evaluating the remainder of the GI tract in case her colonoscopy turned out to be negative, and planned instead to evaluate her urologically or gynecologically. In addition, respondent is criticized for not carrying out his plan to have Dorothy D. evaluated urologically or gynecologically once the colonoscopy turned out to be negative, and never considered asking that the remainder of the GI tract be evaluated.

Respondent’s consultation note to Dr. Morgenstern recommended additional methods of investigation. Respondent as the hematologist managing the patient’s iron deficiency anemia did not have the responsibility of ordering evaluations in other areas. Dr. Morgenstern had that responsibility. Nor did respondent have the responsibility of telling a gastroenterologist how to perform a GI workup. Once Dorothy D. was referred to the GI department, the doctors in that department had the responsibility of taking all appropriate steps to determine the cause of her bleeding if indeed the cause was in her GI tract. The testimony of Dr. Beutler, Dr. Yang, and Dr. Khan support the conclusion that respondent did not violate the standard of care in this respect.

E. It is alleged respondent failed to order additional tests such as vitamin B-12 and folic acid to determine whether Dorothy D. had a problem with poor iron absorption of iron which lead to her iron deficiency anemia. According to Dr. Beutler, the standard of care did not require these tests be performed after the colonoscopy came back negative. The patient was bleeding from her GI tract and there were no other reasonable considerations. His testimony was persuasive that these tests were unnecessary, and therefore respondent did not violate the standard of care.
5. The Fourth Cause for Discipline of the Second Amended Accusation alleges respondent failed to maintain adequate and accurate records in connection with his care and treatment of Lois M., William E., and Dorothy D. Clearly, respondent’s failure to document the correct diagnosis of Lois M. was a failure in this regard. Likewise, respondent failed to document William E.’s performance status, and in particular, a sufficiently objective performance status that would have justified resumption of chemotherapy after respondent had withheld it. Respondent’s records regarding Dorothy D. were satisfactory.

6. The Fifth Cause for Discipline of the Second Amended Accusation alleges respondent knowingly made or signed documents related to the practice of medicine which falsely represented the existence or nonexistence of a state of facts in connection with the diagnosis, care, and management of Lois M. This charge relates to respondent’s diagnosis of low grade in light of the pathology reports of the excisional biopsy which showed the lymphoma to be an intermediate grade lymphoma.

Respondent testified he reviewed Dr. Hernandez’ report, did not agree with it, and spoke to him on several occasions, and spoke to Dr. Azizi as well. His testimony was not credible and was rejected. See Factual Findings 44 and 45. That means respondent either received the reports and misinterpreted or misunderstood them, or never saw them in the first place. In order to find respondent knowingly created false documents, the evidence would have to establish that respondent read and considered the pathology reports of the excisional biopsy and despite the conclusions set forth in them, decided to document an incorrect diagnosis in his records. While that is a possible interpretation, it by no means was established by clear and convincing evidence to a reasonable certainty. It is just as likely that respondent overlooked the pathology reports of the excisional biopsy since they were prepared after he started treatment. Accordingly, it must be concluded the evidence did not establish respondent knowingly made false documents.

7. The Sixth Cause for Discipline of the Second Amended Accusation alleges respondent was dishonest when he testified at the hearing as he did regarding the diagnosis of Lois M.

A trier of fact may consider “any matter that has any tendency in reason to prove or disprove the truthfulness” of a witness at a hearing. (Evid. Code § 780.) Respondent’s testimony was not credible for a number of reasons, including the unreasonableness of it, the lack of documentation to support his claim, his demeanor, his reluctant admission that he made a mistake, and his failure to mention these conversations during his interview with the Board’s investigators and at his deposition. However, that is a far cry from clear and convincing evidence to a reasonable certainty that respondent was dishonest. There was no direct evidence, for example, that specifically contradicted his testimony that he spoke to Dr. Hernandez. Dr. Hernandez did not testify, and submitted a hearsay declaration in which he wrote he did not recall speaking to respondent, but that declaration must be given little weight since he did not testify and the alleged discussions occurred nearly seven years ago. Thus, the only evidence to support the charge of dishonesty are reasonable inferences drawn from circumstantial evidence, and while that is sufficient for a trier of fact to disbelieve a
witness, such evidence is not clear and convincing evidence to a reasonable certainty to establish respondent was dishonest. The charge must fail.

8. The Seventh Cause for Discipline of the Second Amended Accusation alleges respondent committed general unprofessional conduct in connection with the diagnosis of Lois M. It is related to the Sixth Cause for Discipline and depends on a determination that respondent acted dishonestly when he testified. Since it was not established by clear and convincing evidence to a reasonable certainty that respondent acted dishonestly when he testified at the hearing, this charge must fail as well.

9. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234, subdivision (b), gross negligence in connection with his care and treatment of Lois M., was established by reason of Findings 4-14 and 39-41, and Legal Conclusion 2F.

10. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234, subdivision (d), incompetence in connection with his care and treatment of Lois M., was established by reason of Findings 4-14, and 39-41, and 44-45, and Legal Conclusion 2A-G.

11. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234, subdivision (c), repeated negligent acts in connection with his care and treatment of Lois M., was established by reason of Findings 4-14, 39-41, and 44-45 and Legal Conclusion 2A-F.

12. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234, subdivision (c), repeated negligent acts in connection with his care and treatment of William E., was established by reason of Findings 15-25 and 39-41, and Legal Conclusion 3A and B.

13. Cause for discipline of respondent's license for violation of Business and Professions Code sections 2234, subdivision (b), gross negligence, and 2234, subdivision (d), incompetence, in connection with his care and treatment of William E., was not established.

14. Cause for discipline of respondent's license for violation of Business and Professions Code sections 2234, subdivision (b), gross negligence, 2234, subdivision (c), repeated negligent acts, and 2234, subdivision (d), incompetence, in connection with his care and treatment of Dorothy D., was not established by reason of Findings 23-37, 42, 43, and 46, and Legal Conclusion 4A-E.

15. Cause for discipline of respondent's license for violation of Business and Professions Code section 2266, failure to maintain accurate and adequate records, was established by reason of Findings 4-25 and 39-41 and Legal Conclusion 5.
16. Cause for discipline of respondent's license for violation of Business and Professions Code section 2261, knowingly making false documents, was not established by reason of Legal Conclusion 6.

17. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234, subdivision (e), dishonesty, was not established by reason of Legal Conclusion 7.

18. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234, unprofessional conduct, was not established by reason of Legal Conclusion 8.

19. Cause to require respondent to reimburse the Board for its costs of investigation and prosecution of this matter pursuant to Business and Professions Code section 125.3 was established. However, the amount must be reduced because complainant failed to establish respondent violated the Medical Practice Act in connection with his care and treatment of Dorothy D. Based on the evidence introduced at the hearing and the amount of time devoted to the charges relating to Dorothy D., it is reasonable to conclude that the case involving Dorothy D. constituted one-third of the entire case brought against respondent. Accordingly, the amount of investigation and prosecution costs must be reduced by that amount, from $38,449.02 to $25,760.84.

20. Respondent argues that laches applies to the Lois M. and William E. cases. For laches to apply, the burden is upon respondent to establish the delay was unreasonable and caused him to be prejudiced. Fahmy v. Medical Board of California (1995) 38 Cal.App.4th 810; Lam v. Bureau of Collection (1995) 34 Cal.App.4th 29; Gates v. Department of Motor Vehicles (1979) 94 Cal.App.3rd 921, 925. In Lam, the court held a delay of three years between discovery of the facts and the filing of the accusation did not warrant dismissal of the charges on the ground of laches because the licensee did not establish prejudice. In contrast, in Gates, a delay of less than 16 months was not justified, and the licensee established prejudice. The Court of Appeal upheld the trial court's dismissal of the accusation on the ground of laches.

Respondent presented no evidence to establish a delay was unreasonable or he was prejudiced. The record does not show when the Board learned of the cases involving Lois M. and William E. or when it started its investigations. There were apparently civil actions brought in those matters, but the record does not indicate whether the Board learned of the cases through a report of a settlement, award, or judgment, or a consumer complaint. Thus, the only information in the record are the dates of the events which occurred in 1998 and 1999, and the date the original accusation was filed, December 2, 2003. That is insufficient to determine if there was a delay.

In addition, respondent did not establish prejudice. He points to Dr. Hernandez' inability to recall the Lois M. case and the absence of his original report in the Kaiser Fontana chart as evidence of prejudice. Dr. Hernandez did not testify and submitted two declarations, one for each side. His report was introduced into evidence and dissected by
several witnesses. His testimony about his findings would have added little, if anything. There is no reason to believe any delay caused his report not to be in the Kaiser Fontana chart. Likewise, there is no reason to believe any delay caused lab information not to be in William E.'s chart. All three cases were based on voluminous amounts of information, and expert interpretation of them. Respondent's claim of laches is without merit.

21. In order to properly assess the penalty to be imposed in this case, factors in mitigation and aggravation must be considered and weighed. In mitigation, this is the first disciplinary action brought against respondent and it involves only two patients. Respondent's treatment of the two patients occurred six and seven years ago. He is board-certified and was recently recertified. He is well-respected by other physicians and patients.

In aggravation, respondent expressed no remorse for his conduct, even though two of his patients died. He was unwilling to admit he made any mistakes other than a failure to correctly document his diagnosis of Lois M.

For violations of Business and Professions Code section 2234, subdivisions (b), (c), and (d), the Board's Disciplinary Guidelines call for a revocation, stayed, a five-year period of probation and terms and conditions tailored to the violations that were established. The thrust of this case was respondent's care and treatment of Lois M. and William E. That must be addressed. The other charges are minor ones and do not require imposition of additional penalties.

ORDER

Physician's and surgeon's certificate number A 52005 issued to respondent Sunil Patel, M.D., is hereby revoked. However, the revocation is stayed and respondent is placed on probation for five (5) years on the following terms and conditions:

1. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision, Accusation, and any other information that the Division or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.
Based on respondent’s performance and test results in the assessment and clinical education, the Program will advise the Division or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent’s practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program’s determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent’s initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

After respondent has successfully completed the clinical training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include 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, or until the Division or its designee determines that further participation is no longer necessary.

Failure to participate in and complete successfully the professional enhancement program outlined above is a violation of probation.

2. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Division or its designee for its prior approval an 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, limited to classroom, conference, or seminar settings. 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 Division 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.
3. **Monitoring - Practice**

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Division 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 Division, 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 Division 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.

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. Upon reasonable notice from the monitor, respondent shall make all records available for inspection and copying by the monitor on the premises during business hours and shall retain the records for the entire term of probation.

The monitor(s) shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent’s performance, indicating whether respondent’s practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Division 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 5 calendar days of such resignation or unavailability, submit to the Division 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 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.
In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, 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.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

4. Ethics Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in ethics, at respondent’s expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation.

An ethics 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 Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division 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 Division 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.

5. 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, at respondent’s expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

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 Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division 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 Division 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.

6. **Notification**

Prior to engaging in the practice of medicine the respondent shall provide a true copy of the 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 Division or its designee within 15 calendar days.

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

7. **Supervision of Physician Assistants**

During probation, respondent is prohibited from supervising physician assistants.

8. **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.

9. **Quarterly Declarations**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, 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.

10. **Probation Unit Compliance**

Respondent shall comply with the Division’s probation unit. Respondent shall, at all times, keep the Division informed of respondent’s business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in respondent’s place of residence. Respondent shall maintain a current and renewed California physician’s and surgeon’s license.
Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

11. Interview with the Division or its Designee

Respondent shall be available in person for interviews either at respondent’s place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

12. Residing or Practicing Out-of-State

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside 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; Probation Unit Compliance; and Cost Recovery.

Respondent’s license shall be automatically cancelled if respondent’s periods of temporary or permanent residence or practice outside California totals two years. However, respondent’s license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

13. Failure to Practice Medicine - California Resident

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and
conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent’s license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

14. Completion of Probation

Respondent shall comply with all financial obligations (e.g., cost recovery, 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.

15. 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 Division, 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 Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

16. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent’s license. The Division reserves the right to evaluate respondent’s request and to exercise its discretion 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 Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent’s license shall be deemed disciplinary action.
If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

17. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

This Decision Pursuant to Stipulation shall be deemed effective as of November 8, 2005.

IT IS SO ORDERED this second day of March 2006.

__________________________
CATHERINE T. CAMPISI, Ph.D.
Panel B Member

__________________________
RONALD L. MOY, M.D.
Chairperson, Panel B
Division of Medical Quality
Medical Board of California
EXHIBIT A
STIPULATION FOR REMAND and ORDER

The parties, petitioner Sunil Patel, M.D. and respondent, the Medical Board of California (hereafter "Board" or "respondent"), by and through their respective counsel, hereby stipulate to the following:

1. Petitioner, Sunil Patel, M.D., is represented in this proceeding by attorney Paul Spackman, Esq., by Jungerich and Spackman, A Professional Law Corporation.

2. Respondent, Medical Board of California, is represented by Bill Lockyer, Attorney General of the State of California, by Beth Faber Jacobs, Deputy Attorney General.

3. The Executive Officer of respondent Board filed a Second Amended Accusation No. 09-2002-135285 against petitioner's medical license. An 11 day administrative hearing was held on the charges. Following the hearing, on or about August 5, 2005, the Administrative Law Judge presiding over the matter issued a Proposed Decision finding that
petitioner engaged in unprofessional conduct and recommending that discipline be imposed on
petitioner's license to practice medicine in California. By letter dated January 9, 2006, petitioner
was notified by respondent Board's Probation Unit that the Decision had become effective by
operation of law on November 8, 2005. To avoid any confusion regarding the effective date of
the Decision in administrative case No. 09-2002-135285, the Board's Probation Unit extended by
65 days the dates and time frames for commencing the Decision's Order, including its
probationary terms and conditions.

4. On or about December 5, 2005, petitioner filed the instant petition for writ of
mandate against respondent Board, challenging the findings and the penalty imposed by the
Board in its Decision in administrative case No. 09-2002-135285.

5. On or about February 3, 2006, Patrick Mariette, Judge Presiding of the above-
entitled Superior Court, heard petitioner's ex parte request to stay the imposition of the Decision.
At the conclusion of the ex parte hearing, the Court granted a partial stay of the Board's
Decision, specifically staying probation term and condition number 18 - that part of the
Decision's Order requiring that petitioner pay cost recovery. The Court denied the remainder of
petitioner's stay request. The Notice of Ruling Granting Partial Stay and Denying the Remainder
of the Stay Request was filed on or about February 9, 2006.

6. The parties wish to resolve this matter without further litigation or court
appearance. Therefore, through their respective counsel, the parties agree as follows:

a. The parties intend to settle this mandate action and dispute concerning
discipline on petitioner's medical license through mutually agreed-upon
modifications to respondent Board's Decision imposing discipline on petitioner's
medical license;

b. The parties request that the Superior Court, without ruling on the merits
of the petition for writ of mandate, remand the matter to respondent Medical
Board for further consideration, thereby giving the Board jurisdiction to take
further action to modify its Decision in administrative case No. 09-2002-135285:
c. David T. Thornton, Executive Officer of respondent Board, agrees that upon remand, he will recommend the Board modify its Decision in administrative case No. 09-2002-135285, effective November 8, 2005, by issuing a “Decision Pursuant to Stipulation” that retains the provisions currently in the Board’s Decision, with the following exceptions:

A. Two sentences in the Decision’s Legal Conclusion, paragraph 21 (regarding mitigation, aggravation, and penalty), will be eliminated so that Legal Conclusion 21 in the “Decision Pursuant to Stipulation” shall state:

“In order to properly assess the penalty to be imposed in this case, factors in mitigation and aggravation must be considered and weighed. In mitigation, this is the first disciplinary action brought against respondent and it involves only two patients. Respondent’s treatment of the two patients occurred six and seven years ago. He is board-certified and was recently recertified. He is well respected by other physicians and patients.

In aggravation, respondent expressed no remorse for his conduct, even though two of his patients died. He was unwilling to admit he made any mistakes other than a failure to correctly document his diagnosis of Lois M.

For violations of Business and Professions Code section 2234, subdivisions (b), (c), and (d), the Board’s Disciplinary Guidelines call for revocation, stayed, a five year period of probation and terms and conditions tailored to the violations that were established. The thrust of the case was respondent’s care and treatment of Lois M. and William E. That must be addressed. The other charges are minor ones and do not require the imposition of additional penalties.”

B. The term of probation shall be modified so that in the “Decision Pursuant to Stipulation,” petitioner (respondent in the administrative case) shall be placed on probation for a period of five (5) years;

///
C. The term and condition of probation related to a practice monitor (identified in the Decision's Order as "Number 3 - Monitoring-Practice") shall be modified to eliminate the requirement that petitioner (respondent in the administrative proceeding) make all records available for "immediate" inspection by the practice monitor. Instead, in the "Decision Pursuant to Stipulation," petitioner will be required to provide records for the monitor's inspection and copying "upon reasonable notice." As such, the 3rd paragraph of probation term and condition number 3 (relating to the practice monitor) in the "Decision Pursuant to Stipulation," shall state:

"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. Upon reasonable notice from the monitor, respondent shall make all records available for inspection and copying by the monitor on the premises during business hours and shall retain the records for the entire term of probation."

D. The order requiring that petitioner take an "Oral and/or Written Examination" (currently a condition precedent to practice, identified in the Decision's Order as term and condition number 6, and entitled "Oral and/or Written Examination"), shall be eliminated and not included in the "Decision Pursuant to Stipulation." Petitioner understands that the elimination of this term and condition shall not alter his obligation to submit to and pass all testing required under the Clinical Training Program in probation term and condition number 1. The "Decision Pursuant to Stipulation" shall continue to include probation term and condition number 1 (entitled "Clinical Training Program") and all its requirements including, but not limited to, the requirement that
petitioner (respondent at the administrative level) submit to and pass an examination or examinations to successfully complete the Clinical Training Program.

E. The order that petitioner have an Actual Suspension of sixty days (currently identified in the Decision as term and condition number 7, and entitled "Actual Suspension") shall be eliminated and not included in the "Decision Pursuant to Stipulation."

The parties acknowledge that petitioner is currently serving the period of suspension ordered in the Decision. It is the intent of the parties to expedite submission of this Stipulation for Remand to the Court and, assuming it is Ordered by the Court, expedite submission to a Panel of the Board’s Division of Medical Quality, so that further action can be taken by the Board within 30 days of the parties' signature to this Stipulation for Remand.

F. The order that petitioner pay Cost Recovery (currently identified in the Decision’s Order as probation term and condition number 18), shall be eliminated and not included in the "Decision Pursuant to Stipulation."

7. The parties agree that respondent Board’s counsel may confer with the Division of Medical Quality of the Medical Board ("Division") or its staff, without notice to or the presence of petitioner, to recommend or facilitate issuance of a Decision consistent with this Stipulation for Remand. The parties also agree that the Division may, without further notice, issue and enter a new Decision which will be called "Decision Pursuant to Stipulation" and will be consistent with the provisions of this Stipulation for Remand. The "Decision Pursuant to Stipulation" shall be effective as of November 8, 2005 and the dates for commencing the terms and conditions shall remain those identified by the Board’s Probation Unit in its letter dated January 9, 2006, referred to above, in paragraph 3 of this Stipulation for Remand.
8. In exchange for respondent Board entering into this Stipulation, petitioner Sunil Patel, M.D., will dismiss this Superior Court mandate action without prejudice within ten days of receipt of the Stipulation for Remand signed as an Order by the Court and furnish the Board with a conformed copy of the document showing the entry of Dismissal. Thereafter, within ten days of receipt of the Board’s “Decision Pursuant to Stipulation,” petitioner, Sunil Patel, M.D., shall dismiss this Superior Court mandate action with prejudice and furnish the Board with a conformed copy of the document showing the Entry of Dismissal with prejudice.

9. Each party will bear his or its own costs, including attorney fees.

10. The parties agree that the resolution reached in this matter shall resolve all issues concerning administrative case No. 09-2002-135285, including, but not limited to, the Second Amended Accusation, respondent’s Decision that became effective by operation of law on November 8, 2005, Patel v. Medical Board, Sacramento County Superior Court, Case No. 05CS01684, and all issues arising from or related to these matters. Petitioner, having discussed this matter with his attorney, understands that by entering into this Stipulation for Remand, he is waiving any cause of action or avenue of appeal that arose, or could have arisen from the Second Amended Accusation, Case No. 09-2002-135285, from respondent’s Decision effective by operation of law on November 8, 2005, and his mandate action in Patel v. Medical Board, Sacramento County Superior Court Case No. 05CS01684.

11. This Stipulation for Remand and Order is intended by the parties to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter, and to resolve all charges, allegations and issues raised in the Second Amended Accusation, Case No. 09-2002-135285.

12. This Stipulation for Remand will be null, void and unenforceable if the Superior Court does not adopt the Stipulation for Remand by signing it as an Order, if petitioner fails to file either of the required Requests for Dismissal, if petitioner fails to send a conformed copy of the required Dismissals to Respondent Board; or if the Board fails to issue its "Decision Pursuant to Stipulation" consistent with the provisions of this Stipulation.
13. The parties agree that facsimile copies of this Stipulation for Remand, including facsimile signatures thereto, shall have the same force and effect as the original signed Stipulation for Remand and Order.

Dated: 2/16/06

SUNIL PATEL, M.D., Petitioner

Dated: 2/18/06

PAUL SPACKMAN, Esq.
Jungenirch & Spackman,
A Professional Law Corp.
Attorney for Petitioner

Dated: Feb. 9, 2006

BILL LOCKYER, Attorney General

By

BETH FABER JACOBS
Deputy Attorney General
Attorney for Respondent Medical Board

ORDER

GOOD CAUSE APPEARING, the Stipulation For Remand is hereby approved.

The matter is hereby remanded to the Medical Board for action in conformity with this Stipulation for Remand.

DATED: FEB 15 2006

PATRICK MARLETTE
JUDGE OF THE SUPERIOR COURT

STIPULATION FOR REMAND and ORDER
BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended )
Accusation Against: )
) )
SUNIL J. PATEL, M.D. ) File No. 09-2002-135285
) )
) )
) )
Physician's and Surgeon's ) OAH No. L-200404060
Certificate No. A-52005 )
) )
Respondent. )

DECISION

No action having been taken on the Proposed Decision in the above-referenced matter, the attached decision hereby took effect by operation of law at 5:00 p.m. on November 8, 2005.
BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: SUNIL PATEL, M.D.
9985 Sierra Avenue
Fontana, CA 92335

Physician’s and Surgeon’s Certificate
No. A 52005

Case No. 09-2002-135285
OAH No. L2004040660

Respondent.

PROPOSED DECISION

On June 20-25, 28-30, and July 19, 2005, in Riverside, California, and on July 20,
2005, in San Diego, California, Alan S. Meth, Administrative Law Judge, Office of
Administrative Hearings, State of California, heard this matter.

Richard D. Hendlin, Deputy Attorney General, represented complainant.

Paul Spackman, Attorney at Law, represented respondent.

The matter was submitted on July 22, 2005.

FACTUAL FINDINGS

Jurisdiction

1. On December 2, 2003, Ron Joseph, Executive Director, Medical Board of
   California (Board), filed Accusation No. 09-2002-135285 in his official capacity.
   Respondent filed a timely Special Notice of Defense. Complainant filed a First Amended
   Accusation on January 11, 2005, and on July 1, 2005, complainant filed a Second Amended
   Accusation.
The second amended accusation alleges respondent committed gross negligence, repeated negligent acts, and was incompetent in his care and treatment of three patients between 1998 and 2001. The second amended accusation also alleges respondent failed to maintain adequate and accurate records, knowingly made false documents, was dishonest, and committed general unprofessional conduct in connection with his treatment of these three patients.

2. On June 7, 1993, the Board issued Physician's and Surgeon's certificate No. A 52005 to respondent.

Respondent's Background

3. Respondent is 44 years of age. He attended college and medical school in India, graduating from the South Gujarat University/Government Medical College in Surat in January 1985. After completing an internship in 1986, he came to the United States. He did a residency in pediatric pathology at the Harvard Medical School/Children’s Hospital in Boston and a three-year residency in internal medicine at the Northshore Medical Center in Salem, Massachusetts. He then did a fellowship in hematology/oncology at the City of Hope Medical School and Harbor-UCLA Medical Center for two years. He became board-certified in internal medicine in 1993 or 1994 and in oncology in 1995; he was recertified in both fields in 2003.

Respondent began working for Arizona Oncology Associates in Yuma, Arizona, in 1995. He returned to California in 1997 and worked for Inland Hematology/Oncology Medical Group in San Bernardino for one year, and in October 1998, joined Kaiser Permanente and worked at the Medical Center in Fontana. He is presently in charge of the hematology/oncology department and had been a member of the cancer and transfusion committees.

Lois M.

4. On September 24, 1998, Lois M., then age 71, underwent a CT scan at Kaiser Permanente Fontana Medical Center (Kaiser Fontana). It revealed extensive periaortic masses extending into the pelvis on both sides, with the findings suggestive of lymphoma. A small right pleural effusion was also seen. Lois M. then underwent a needle biopsy. Dr. Sung Shin diagnosed malignant lymphoma, B-cell type, and “morphologic and immunologic features consistent with follicular lymphoma, small cleaved-cell type.” In the comment section of his report, Dr. Shin wrote:

The morphologic and flow cytometric findings indicate the presence of B-cell malignant. Even though follicular architecture is not seen in this needle biopsy specimen, the features are most consistent with follicular lymphoma of small cleaved cell type. For accurate subclassification of this lymphoma, an open biopsy of the lymph node is suggested.
On October 5, 1998, Lois M. underwent an excisional biopsy of two lymph nodes from the left groin.

5. Respondent first saw Lois M. on October 9, 1998 and prepared two short handwritten notes and a longer consultation report. In one of his handwritten note, respondent indicated his impression was “follicular small cleaved NHL [non-Hodgkins lymphoma], S/P [status post] excisional biopsy.” He did not know the stage since the staging work was still in progress. In the other note, respondent wrote his impression was a low grade NHL (follicular small cleaved cell).

In the consultation report, respondent wrote the needle biopsy revealed findings consistent with low-grade lymphoma and the morphologic and immunologic features most consistent with follicular lymphoma, small cleaved cell type. His impression was “A 71-year-old female with a history of diet controlled diabetes and hypertension now recently diagnosed with follicular low grade small clear (sic) lymphoma.” In several other places in the note, respondent indicated the patient had a low grade follicular small cleaved cell type lymphoma.

Respondent’s plan was to treat Lois M. with Fludarabine chemotherapy. She received four cycles of Fludarabine, 50 mg. I.V. given daily for five days of each cycle starting on October 12, November 16, December 21, 1998, and January 22, 1999. On the third cycle, Lois M. received four days of chemotherapy instead of five.

6. The excisional biopsy of October 5, 1998 was analyzed by two pathologists. Dr. F. Azizi at Kaiser Fontana dictated a report in which his final diagnosis was “Malignant lymphoma, mixed small and large cell, diffuse (see BT report).” It appears the report was typed on October 16, 1998. This would be interpreted as an intermediate grade malignant lymphoma.

Dr. Antonio Hernandez, a hematology pathologist from the Kaiser Medical Center in Los Angeles, analyzed the same specimen. His final diagnosis was:

1. Intermediate grade-malignant lymphoma, diffuse mixed small and large cell type, focally follicular (International Working Formulation)

2. Malignant lymphoma, mixed small and large cell, diffuse (Rappaport Classification)

3. Immunologic characterization on paraffin and frozen sections: positive for CD19, CD20, CALLA, and BCL-2 (B-cells).

Dr. Hernandez described his microscopic findings. Among other findings, he indicated “the pattern is diffuse with many small and moderately irregular lymphocytes with clearish cytoplasm admixed with scattered medium and large transformed cells (about 10%).” In a Note, Dr. Hernandez wrote “The findings are not inconsistent with follicular center cell origin.”
7. Respondent next saw Lois M. on October 12, 1998 when she began her chemotherapy and had a bone marrow biopsy.

8. On October 26, 1998, a CT scan of the chest was performed and it revealed a moderate right pleural effusion. On November 26, following her second cycle of chemotherapy, blood tests revealed an elevated glucose of 339, an elevated creatinine of 1.5, and an elevated BUN of 30.

9. Respondent next saw Lois M. on November 9, 1998. His diagnosis remained “low grade NHL.” Her lab results were low and he withheld chemotherapy for a week. On November 16, when respondent saw the patient, his diagnosis remained low grade NHL. He resumed chemotherapy. On December 21, 1998, respondent saw Lois M. and his diagnosis remained low grade NHL. She received her third cycle of chemotherapy. On January 18, 1999, respondent withheld chemotherapy because of a low white blood count. His diagnosis remained low grade NHL. Respondent saw Lois M. again on January 25 and resumed chemotherapy. Her diagnosis remained low grade NHL. Respondent withheld chemotherapy on February 22, 1999 because of a low white blood count and the patient was suffering from sinusitis. Her diagnosis remained low grade NHL. On March 25, 1998, respondent saw the patient and his diagnosis remained low grade NHL. His plan was to observe her. The patient’s next visit to respondent was on April 22, 1999, at which time his plan was to continue to observe her, and follow-up in two months. He wrote the diagnosis was “low grade NHL (follicular small cleaved cell).” Respondent’s chart note of June 22 was similar to the April 22 note.

10. On August 6, 1999, respondent discovered a 5 x 4 cm. mass in Lois M.’s left groin, associated with swelling of the left extremity. His diagnosis was “recurrent low grade NHL with left inguinal adenopathy and lower left extremity swelling.” He decided to repeat the staging evaluation and start chemotherapy with the CVP regimen. This consisted of cycles of cytoxan and vincristine to be given intravenously, and prednisone to be given orally for five days starting on the first day. Respondent wrote in his chart “prednisone 100 mg/d x 5d.” He gave her a prescription for prednisone, 50 mg., ten pills, with one pill to be taken twice a day by mouth with meals for five days, with six refills. The cycle was to start on August 9. Respondent ordered CT scans to be performed as part of the re-staging evaluation but Lois M. did not keep the appointment. Respondent did not set up another appointment for re-staging purposes.

11. Lois M. began her first cycle of intravenous CVP chemotherapy on August 9, 1999, receiving cytoxan 1600 mg. and vincristine 2 mg. Lois M. started taking the prednisone orally on August 6 through August 9. On August 9, Sherry M., Lois M.’s daughter, spoke briefly with respondent and then refilled the prednisone prescription. She received two bottles of prednisone, each containing ten pills. Lois M. continued to take two prednisone pills daily until August 27.
Respondent next saw Lois M. on August 20. Her lymph node had significantly improved and he planned to follow-up on August 27, and he ordered blood tests. His diagnosis remained low grade NHL.

The results of the blood work as of August 21 showed abnormal BUN and creatinine levels.

12. After Lois M. began taking the prednisone on a daily basis, her condition began to change. She became forgetful and lethargic, she lost her appetite, she would become irate, loud, and impatient, her handwriting changed and became sloppy, and she became too weak to walk.

13. Lois M. returned to Kaiser for her second cycle of chemotherapy on August 27, 1999. She was in a wheelchair and was accompanied by Sherry M. After Lois M. received her chemotherapy and had blood drawn, she saw respondent. She complained of confusion. Sherry M. asked respondent what was wrong with her mother, and mentioned the pills. Respondent asked what pills. Sherry M. said Lois M. had been taking prednisone, 100 mg. a day, continuously for 20 days. Respondent said she was supposed to take it for five days. Sherry M. showed him the pill bottle. Respondent looked at the bottle and scolded Lois M. for taking the pills. Lois M. at that time was confused, disoriented, and her head was slumped as she sat in the wheelchair. Respondent told her to discontinue the prednisone and withheld the chemotherapy. Respondent wanted her to return on September 3. He did not give Sherry M. any instructions regarding her mother’s diabetes and did not tell her anything about the side effects from taking an excessive amount of prednisone.

The CBC performed that day showed an elevated white blood count with most of the cells being granulocytes at 96.1 percent, and elevated creatinine and BUN levels.

14. On September 1, 1999, Lois M. was seen at the emergency room at Kaiser with decreased appetite, weakness, some questionable altered mental status, and polydipsia. Blood tests showed a significantly increased level of glucose. Among the impressions was diabetic ketoacidosis secondary to the lymphoma therapy, and the doctor planned to rule out sepsis and pneumonia. A chest x-ray revealed a cavitary infiltrate which was determined to be Aspergillus, a rare form of fungus. She received aggressive treatment. However, on September 18, 1999, Lois M. died. The cause of death was deemed to be multi-organ failure due to Aspergillus pneumonia with abscess, inadvertent prolonged use of prednisone, and NHL. Contributing causes were diabetes mellitus and hypertensive cardiovascular disease.

William E.

15. On December 1, 1997, William E., a 72-year-old man, underwent a right thoracoscopic biopsy to a posterior thoracic mass, and on December 3, respondent performed a bone marrow biopsy. The biopsy of the thoracic mass revealed a malignant lymphoma, B-cell type, intermediate grade composite, follicular predominantly large cell and marginal zone type. The bone marrow biopsy revealed no evidence of lymphoma.
16. Respondent saw William E. on December 2, 1997. His plan was to await the final pathologic reports before deciding on treatment. On December 15, 1997, respondent saw William E. at his office at the Inland Hematology Oncology Medical Group. Respondent’s diagnosis was intermediate grade NHL and after discussion with the patient and his family, William E. would be scheduled for chemotherapy. The regime was to be CHOP, which consisted of cytoxan, adriamycin, vincristine, and prednisone. Respondent planned six cycles of chemotherapy and based on his current performance status, respondent was to decrease the dose of cytoxan and adriamycin by 20 percent. The patient’s vital signs were normal; his blood pressure was 141/88.

17. William E. received his first cycle of chemotherapy on December 19, 1997. Respondent saw him that day. He received three more cycles of therapy beginning on January 19, February 9, and March 2, 1998.

18. On March 14, 1998, William E. was hospitalized at the St. Bernardine Medical Center in San Bernardino with chief complaints of shortness of breath, left hip pain, and a high temperature. The assessment listed neutropenia (abnormally small numbers of neutrophils well below 500), more than likely the result of his chemotherapy. A CT scan taken while he was in the hospital revealed the tumors had resolved. He was treated for the neutropenia and anemia.

On March 18, 1998, while William E. was still at St. Bernadine, he fell and fractured his right hip fracture. A hemiarthroplasty of the right hip was performed; he tolerated the procedure well. He needed maximal assistance with physical therapy and arrangements were made for further rehabilitation at Shea Convalescent Hospital. He was discharged to Shea on March 21. He remained at Shea until he was transferred to Waterman Convalescent Hospital on March 30.

19. Respondent saw William E. on April 10 at his office. Respondent charted that William E. was currently at Waterman and was receiving physical therapy, and he complained of shortness of breath on exertion. Respondent wrote the patient “has had near complete response from the chemotherapy at this time.” Respondent decided to hold off his additional two cycles of CHOP chemotherapy; he noted William E.’s performance status had decreased. Respondent wrote he would hold chemotherapy until William E.’s performance status had improved.

20. William E. returned to respondent’s office on May 8, 1998. Respondent noted William E. was in a wheelchair and he complained of pain in the left leg. Respondent indicated the patient’s NHL after four cycles of chemotherapy had “complete response.” Respondent decided to “hold off his chemotherapy for an additional two weeks for better improvement in his performance status.”

Respondent next saw William E. on May 22. The patient complained of cough with sputum production, and he was still wheelchair bound. Respondent noted there was no improvement in his performance status after rehabilitation. Respondent again decided to withhold chemotherapy due to his cough with sputum production.
21. On May 29, 1998, William E. returned to respondent’s office. Respondent noted there was no cough or sputum production and no shortness of breath. Respondent described the NHL as “in complete remission.” Respondent decided to give William E. two additional cycles of CHOP chemotherapy, explaining there had been a delay due to the hip fracture. Respondent discontinued the prednisone. He ordered follow-up in ten days with a CBC and platelets. His white blood count that day was 8,400 and his blood pressure was 90/71. William E. received his fifth cycle of chemotherapy that day. On June 12, the white count was 4,800 and his blood pressure was 90/71.

22. William E. received his sixth cycle of chemotherapy on June 19, 1998. Respondent charted the patient complained of a dry cough but no fever, chills, shortness of breath, chest pains, or palpitations. His temperature was normal and his blood pressure was 98/73. His white blood count was 20,700. Respondent gave William E. Cipro 500 mg. for the dry cough, and ordered a CBC with platelets.

William E. did not return for his next appointment with respondent on June 26.

23. On June 30, 1998, William E. was hospitalized with shortness of breath. His creatinine was high and his white blood count was very low. Blood cultures showed the presence of e.coli. William E. was treated aggressively, but he died on July 1.

24. June D. was William E.’s daughter and visited William E. daily while he was at Waterman. During that time, she never saw her father walk, and he was in bed 100 percent of the time during May and June 1998. William E. needed help going to the bathroom, he could not groom himself, his appetite was poor, and walking was painful. William E. was transported to respondent’s office in April, May, and June 1998 by wheelchair van.

Based on her observation of her father’s ability to ambulate, she believed it declined from May 29 to June 19. William E.’s energy level appeared to get worse.

25. The Waterman Convalescent Hospital records for the period of March 30 to June 30 were introduced into evidence. However, respondent never reviewed them and did not base his decisions regarding William E.’s performance status on any information contained within those records.

Dorothy D.

26. On February 15, 1998, Dorothy D., a 56-year-old female, went to the Urgent Care Unit of Kaiser Fontana with, among other things, occult blood, a markedly reduced hemoglobin, and asthmatic bronchitis. Further testing revealed a decreased serum iron level. A surgical consultation was conducted to evaluate her gastrointestinal (GI) bleeding and for other reasons. Dorothy D. was started on oral iron therapy for her anemia. While in the hospital, Dorothy D. refused an endoscopy but she did undergo a single contrast barium enema and a sigmoidoscopy. On February 23, Dorothy D. was seen because of three
separate episodes of melena (dark colored, tarry stools due to the presence of blood) and bright red blood per rectum associated with some diarrhea. On February 24, it was suspected the dark stools were secondary to iron intake. On March 26, she was seen after having been transfused with blood in the hospital and on April 30, she complained of “dark jelly” stools on three occasions. Her hemoglobin was low and she was advised to restart the oral iron. She was scheduled for an upper GI x-ray. On May 4, Dr. Roger, her primary care physician, diagnosed Dorothy D. with anemia, anxiety, and non-compliance. On June 8, she was thought to have anemia secondary to hemorrhoids but on September 27, anoscopy was negative, but her stool was positive for occult blood. Her stool revealed occult blood on February 9, 1999 and on July 19, Dr. Roger indicated Dorothy D. had multiple questions about “diverticular bleed.”

Dr. James Morgenstern, an internal medicine physician, became Dorothy D.’s primary care physician and saw her on October 13, 1999. He noted she had chronic iron deficiency anemia. On December 2, Dr. Morgenstern’s impression was “worsening anemia,” probably from a GI source. He noted she had had an incomplete GI workup consisting of a single contrast barium enema and a flexible sigmoidoscopy in 1998. He indicated he planned to put in a referral to gastroenterology and she needed to be transfused. He also indicated he was going to ask Hematology to see if the patient needed to be considered for alternative iron supplementation such as intravenously if she has recurrent anemia that is not responding to oral iron. On December 13, Dr. Morgenstern placed a requisition for a colonoscopy to rule out a colonic source for the documented iron deficiency anemia. It was received in gastroenterology the next day.

27. Respondent performed a hematology/oncology consultation examination of Dorothy D. on January 5, 2000 due to her iron deficiency anemia. Respondent noted the previous tests and indicated she was awaiting a colonoscopy. He found her hemoglobin was low. Respondent’s impression was progressive anemia with the microcytic indices consistent with iron deficiency anemia. He questioned whether there was a GI blood loss or poor absorption of iron. He discussed with the patient that she had had no improvement in her hemoglobin despite the iron supplement and they would consider IV iron 500 mg. daily for three days. He further indicated that if she had a negative colonoscopy evaluation, she may require either a urologic or gynecologic evaluation to rule out other causes of blood loss. Finally, he indicated if other workups are non-diagnostic, parenteral iron therapy would be continued.

28. Respondent had Dorothy D. begin receiving iron dextran IV on January 12, 2000. She first received a test dose of 25 mg. and then received another 475 mg., for a total dose of 500 mg. Respondent also had iron dextran IV administered on March 6 in a similar fashion, and again on March 13.

29. On January 17, three stool samples were positive for occult blood. Dorothy D. was seen on January 26 for dizziness, night sweats and fever, and anemia. Dr. Houssiere saw her that day and his impression was probable recurrence of iron deficiency anemia from GI bleeding, probably lower GI.
30. Respondent saw Dorothy D. on February 2, 2002 and he again questioned whether she had a GI bleed and stated he was awaiting a colonoscopic evaluation. Respondent saw her again on March 1 for follow-up of iron deficiency anemia and she was still awaiting colonoscopy. Dr. Morgenstern also indicated that day her chronic anemia was not getting better, and on March 24, he noted Dorothy D. had received blood transfusions, she felt fatigued, and he was awaiting colonoscopy. On April 19, 2000, respondent saw Dorothy D. and noted the iron deficiency anemia, she was still awaiting a GI workup, and she would be given oral iron. Again, on May 17, respondent saw Dorothy D. for iron deficiency anemia and ordered iron studies. On June 14, respondent saw Dorothy D. for iron deficiency anemia and noted she was awaiting a GI evaluation. The patient had a low hemoglobin and his plan was to admit her to the Adult Holding Unit for a transfusion and GI evaluation. An upper endoscopy performed on June 15 and a sigmoidoscopy were negative. Her hemoglobin on July 21 was low and she received blood transfusions. The patient cancelled her colonoscopy scheduled for July 28 and on August 8, she received blood transfusions in anticipation of colonoscopy.

31. On August 18, 2000, a colonoscopy was performed on Dorothy D. It was negative.

32. Respondent next saw Dorothy D. on August 21 and his diagnosis included iron deficiency anemia and he questioned the source. He planned to give her oral iron and would schedule her for IV iron.

33. Dr. Morgenstern saw Dorothy D. on August 28 and considered getting a small bowel series. On September 13, her iron was abnormally low.

34. On October 30, 2000, respondent saw Dorothy D. who questioned occult GI bleeding and planned to give her IV iron. He noted she reported melena.

35. On January 28, 2001, Dorothy D.’s hemoglobin was low and she was scheduled for blood transfusions. On January 24, she had rectal bleeding with blood mixed with stools. Her hemoglobin was low and her alkaline phosphatase was increased. She was seen in the emergency room for rectal bleeding.

36. On February 16, 2001, respondent again saw Dorothy D. for iron deficiency anemia and he advised IV iron daily for three days. On March 16, respondent ordered IV iron therapy for three days.

37. Dr. Morgenstern ordered a CT scan on the abnormally elevated alkaline phosphatase and it showed a colonic mass in the ascending/hepatic flexure and a three centimeter cyst in the liver. On June 11, a colonoscopy revealed a large, ulcerated mass in the hepatic flexure. On July 17, a right hemicolectomy and cholecystectomy was performed and pathology revealed a moderately differentiated colonic adenocarcinoma with invasion of the ileum. The tumor was 13.5 cm. by 8.5 cm and it extended into the entire thickness of the
wall to the pericolic adipose tissue. On August 13, 2001, respondent noted Dorothy D. had Duke C, Stage III, T4 N1 Mo colon cancer. Her hemoglobin had improved. The patient received chemotherapy and her anemia subsided after her hemicolecction.

**Expert Witnesses**


Incompetence is distinguished from negligence in that one may be competent or capable of performing a given duty, but negligent in performing that duty. A single act of negligence is not equivalent to incompetence. While a single negligent act under certain circumstances may reveal a general lack of ability to perform licensed duties, thereby supporting a finding of incompetence, a single honest failing in performing those duties, without more, does not constitute a finding of incompetence justifying sanctions. *See Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040.

It is incumbent upon the trier of fact to determine the standard of professional learning, skill and care required of respondent only from the opinions of the physicians, including respondent, who have testified as expert witnesses as to such standard. The trier of fact must consider each such opinion and should weigh the qualifications of the witness and the reasons given for his or her opinion. The trier of fact must give each opinion the weight to which it deems it entitled.

39. Dr. Jacques V. Souadjian was complainant’s expert witness. He attended the American University of Beirut, Lebanon and Oxford University in England before beginning medical school at the University of Ottawa. He graduated in 1963 and after a one-year rotating internship, was a fellow in internal medicine at the Mayo Clinic for three years, and then was a fellow in hematology and oncology at the Mayo Clinic. He is board certified in internal medicine and board certified in hematology in Canada. He is not board certified in the United States in hematology and oncology because those boards did not exist at the time he completed his training.

Dr. Souadjian began his teaching career in 1969 when he became an assistant professor in the Department of Medicine, Hematology Section, at the University of Sherbrooke, Quebec, Canada. He returned to the United States in 1972 and became an assistant adjunct professor at UCI. He also became a consultant and partner in a medical group in Orange County in the field of hematology and oncology, and remained in that position for 24 years. He continued to teach at UCI and is presently a clinical professor of medicine at UCI in the hematology/oncology section. Over the years, among other things,
Dr. Souadjian has served on cancer committees and other committees at St. Joseph’s Hospital in Orange, was the founder and chairman of the Tumor Board at St. Joseph’s, served as the president of the Society of Hematology and Oncology of Orange County, served as a director of the Oncology Unit of Chapman General Hospital, served on a medical ethics review and advisory committee, was the managing editor of the Journal of Infusional Chemotherapy, was a member of the Board of Directors of the American Cancer Society (California Division), and was a district medical consultant for the Board. Since 1997, he has provided consultations and second opinions in the field of internal medicine, hematology, and oncology. He has performed forensic legal work for 35 years and reviewed cases on behalf of plaintiffs and defendants. He has made numerous presentations at professional meetings, has had 37 articles published, and co-authored a book relating to continuous infusional chemotherapy.

Dr. Souadjian was well-qualified to render opinions on the standard of care as it related to respondent’s care and treatment of Lois M., William E., and Dorothy D.

40. Dr. Aziz-Ur-Rehman Khan was respondent’s primary expert witness on the standard of care issues. Dr. Khan attended Forman Christian College in Pakistan for two years and then attended Allama Iqbal Medical College in Lahore, Pakistan for seven years, receiving an MBBS degree in 1982. After doing a one-year internship in internal medicine at the Services Hospital at Punjab University in Lahore, Dr. Khan came to the United States in 1985 and did an internship at the General Hospital at Georgetown University, followed by a two-year residency there. Dr. Khan then did a two-year fellowship at the Los Angeles County-USC Medical Center in medical oncology, and a one-year fellowship there in hematology. Dr. Khan became licensed in California in 1988 and is board certified in internal medicine and medicine oncology. In addition, he supervises the lymphoma/leukemia clinic at the Los Angeles County-USC Medical Center and treats patients at the Norris Cancer Center about six months a year.

Dr. Khan became an assistant professor of clinical medicine at the USC Keck School of Medicine in July 1991, and in 2000 became as associate professor of clinical medicine. He has conducted research in bone marrow transplants and hematological malignancies, and has written a number of peer-reviewed manuscripts and abstracts.

Dr. Khan was well-qualified to render opinions on the standard of care as it related to respondent’s care and treatment of Lois M., William E., and Dorothy D.

41. Dr. Soudajian testified respondent’s care and treatment fell below the standard of care in a number of respects in connection with his care and treatment of Lois M., William E., and Dorothy D. Dr. Khan testified respondent’s care and treatment of those patients did not fall below the standard of care. Both witnesses are equally well-qualified to render opinions on the care and treatment of patients suffering from lymphoma and iron deficiency, although Dr. Soudajian had somewhat more experience than did Dr. Khan. The difference in experience, however, is not by itself sufficient to determine that Dr. Soudajian’s testimony is entitled to greater weight than Dr. Khan’s.
What is significant and determinative, however, is the relative objectivity of Dr. Soudajian and Dr. Khan, and there was a considerable difference. That difference appeared most evidently in their analyses of the issue relating to the diagnosis of Lois M. Respondent began treating Lois M. after he had received the results of the needle biopsy but before he had received the results of the excisional biopsy. According to Dr. Soudajian, that was below the standard of care. He gave respondent the benefit of the doubt by concluding respondent’s mistake was an innocent one, in that respondent did not have the result of the excisional biopsy and should have waited until he received it. However, respondent testified at the hearing that he received the result of the excisional biopsy and even spoke to Dr. Hernandez who did not change his diagnosis, and yet in his opinion Lois M. suffered from a low grade lymphoma. Based on that additional piece of evidence, Dr. Soudajian testified on rebuttal that he believed respondent’s departure from the standard of care was an extreme one, and could no longer be characterized as innocent. He reasoned that respondent should have accepted the opinion of the pathologist on the grade of the lymphoma, and if he did not, he should have viewed the slides himself or requested another opinion, stopped treatment until the grade could be determined, and documented all that in the chart. Respondent did none of this. Dr. Soudajian’s reading of the medical record is a reasonable one, and his conclusions are compelled by the evidence contained in the medical records and respondent’s testimony. His testimony was objective, and it showed he was willing to give respondent the benefit of the doubt.

Dr. Khan testified respondent did not depart from the standard of care because he classified the lymphoma and treated Lois M. appropriately, based on a different and newer lymphoma classification system. Under this system, called the REAL (for Revised European-American Classification of Lymphoid Neoplasms) and established by the World Health Organization, the grade of lymphoma is determined by the cell of origin rather than the appearance of cells under the microscope. In his opinion, Dr. Hernandez’ findings and report showed the lymphoma to be a grade two lymphoma and was therefore an indolent one which could be treated in the same manner as a low grade lymphoma under the older system.

Neither Dr. Hernandez nor respondent used the REAL system for classifying lymphomas in 1998. Nor did Dr. Azizi. It is obvious from a reading of respondent’s medical records that he misdiagnosed Lois M.’s lymphoma as a low grade lymphoma based upon the needle biopsy, and nothing more. Respondent either did not read or simply ignored the two pathology reports of the excisional biopsy, which came in after he began treatment, and which showed the lymphoma was an intermediate grade lymphoma. The only question is the degree of respondent’s mistake. Yet Dr. Khan defended the indefensible.

Furthermore, Dr. Soudajian, supported by authoritative texts, testified that under the REAL classification, the lymphoma described by Dr. Hernandez in his pathology report would be considered an aggressive lymphoma and treated with a combination of chemotherapy agents, rather than the one agent respondent used. The treatment under the REAL classification of an aggressive lymphoma would be the same as the treatment of an intermediate grade lymphoma under the International Working Formulation classification Dr. Hernandez used. Dr. Soudajian’s testimony on this point is more persuasive than Dr. Khan’s.
By trying to defend respondent’s misdiagnosis of Lois M. in the way he did — by referring to a classification system that was not in use at Kaiser Permanente in 1998, by not candidly saying that under the REAL system of classifying lymphomas, respondent’s treatment was still incorrect, and by failing to acknowledge that respondent never considered the possibility that Lois M. was suffering from an intermediate grade lymphoma — Dr. Khan showed he was not objectively viewing respondent’s care and treatment of the patient and instead was offering an ill-conceived and pre-conceived defense. Since his opinion on this subject cannot be trusted, his opinions on respondent’s care and treatment on other subjects similarly cannot be trusted.

42. Dr. Russell Yang practices gastroenterology and testified as an expert on that subject relating to respondent’s care and treatment of Dorothy D. After finishing college at Trinity College in Hartford, Connecticut, Dr. Yang received a master’s degree and a Ph. D from MIT in nutritional biochemistry and metabolism in 1987. He attended Baylor Medical School and did his internship and residency at Duke University in internal medicine. He then did a fellowship in gastroenterology, first at the University of Texas and then at the Los Angeles County-UCS Medical Center. He is a full-time professor at the USC Keck School of Medicine and does clinical research in the field of gastroenterology. He is well-qualified to testify on the subject of gastroenterology.

43. Dr. Ernest Beutler testified for respondent on the issue of the propriety of using iron dextran to treat Dorothy D.’s iron deficiency anemia. Dr. Buetler viewed himself as a physician/scientist. He stopped seeing patients about six years ago. He is board certified in internal medicine and hematology, and has practiced medicine for more than 50 years. He is presently the Chairman of the Department of Molecular and Experimental Medicine at Scripps Research Institute in La Jolla and performs consultations for other physicians. His curriculum vitae lists 19 books, 778 journal articles, 274 chapters, 45 editorials, and 177 abstracts that he has written. Among the chapters he wrote was one in Williams Hematology, an authoritative text relating to iron deficiency, which other experts referred to during the course of their testimony. He has conducted research on iron deficiency and metabolism. Dr. Beutler was extremely well qualified to render opinions in his field of expertise.

Respondent’s Testimony Relating to Lois M.

44. Respondent testified at the hearing that he considered Lois M.’s lymphoma to be a low grade one and treated her accordingly with a single agent. He never changed his diagnosis. He testified he spoke to both Dr. Azizi and Dr. Hernandez during the second or third week of November 1998 about their excisional biopsy findings. According to respondent, Dr. Azizi told him he did gross cutting of the specimen and then sent it to a Kaiser hospital in Los Angeles, and when he spoke to Dr. Hernandez either the same or the next day, they compared the results of the needle biopsy with the results of the excisional biopsy, and they were comparable. Respondent testified Dr. Hernandez told him he would review the results of the needle biopsy, and after he did so, his findings would not change.
Respondent testified he received a fax copy of Dr. Hernandez’ report which he had placed in the Kaiser Fontana medical chart.

45. Respondent did not document any discussion with Dr. Azizi or Dr. Hernandez in his chart. He did not make any notes of his conversations with them. Dr. Hernandez’ report was not contained within the original Kaiser Fontana chart. Respondent did not document his disagreement with Dr. Hernandez relating to the grade of the lymphoma, and acknowledged that the pathologist diagnosed the grade.¹ He acknowledged he had an ethical and professional responsibility to accurately document the diagnosis and if he disagreed with the pathologist, to set forth his reasons. Respondent was interviewed by an investigator and consultant with the Board and never mentioned any discussion with Dr. Hernandez, nor did he mention it during his deposition taken in connection with a civil action brought against him. Respondent’s testimony that he had several conversations with Dr. Hernandez and Dr. Azizi and that Dr. Hernandez told him the results of the needle biopsy and the excisional biopsy were comparable when they plainly are not is not credible and is rejected.

Respondent’s Testimony Relating to Dorothy D.

46. Respondent testified that at the time he first examined Dorothy D., he knew Dr. Morgenstern had sent in a referral for a colonoscopy, and he told Dr. Morgenstern he would manage the patient’s anemia. He explained his reference to urologic and gynecologic workups was a recommendation to the primary care physician in case the GI workup did not disclose the source of her bleeding, and he pointed to her history of heavy menses and hematuria. Respondent envisioned his role as a consultant helping the primary care physician manage the patient.

Respondent testified he discussed the benefits, risks, and side effects of IV iron with Dorothy D., she understood them, and agreed to the IV iron therapy. Respondent testified he used the medication cautiously, and he gave it to her before the colonoscopy was performed because she had had persistent anemia which was not improving with the oral iron and she had received transfusions. He felt the risk to the patient of transfusions was greater than giving her IV iron therapy.

Respondent testified he was becoming frustrated with the GI department because the colonoscopy was taking so long. He testified that every time he saw Dorothy D., either he or his nurse called the GI department to find out when the colonoscopy would be scheduled. Each time he called, he was told she was on the list and someone would triage her and she would be scheduled. When calling the GI department proved unsuccessful, respondent admitted Dorothy D. to the Adult Holding Unit when her hemoglobin was reported to be low, she was symptomatic from anemia, and was weak. He hoped the admission would result in a quicker GI workup and asked the GI department to rule out GI bleeding as a cause of her anemia. He wanted a workup that went beyond a colonoscopy and included the small

¹ Respondent later changed his testimony and said it was the responsibility of the oncologist to clarify a diagnosis made by a pathologist because it could be misleading, and he had a responsibility as the oncologist to make a clinical diagnosis of the grade. That testimony was contradicted by Dr. Souadjian.
bowel as well. A GI workup was done, but it did not include a colonoscopy, and it did not detect the cause of her bleeding.

Respondent testified Dorothy D. never experienced any adverse reactions from his administration of IV iron, and that each time she received the medication, her hemoglobin improved. He testified he did not ask for a second colonoscopy immediately after the first one because he had no reason to second guess the radiologist at that time.

Respondent explained he did not order tests such as vitamin B-12 and folic acid because they were not related to iron deficiency anemia. Rather, they concerned a different form of anemia.

Character Evidence

47. Dr. Craig Arakiki is a pulmonary critical care physician and works for Kaiser Fontana. He has practiced medicine for 20 years, and has known respondent for seven years. They work in the same building and there have been many occasions when they treated the same patient. On such occasions, they often discuss the patient. Based on his frequent contact with respondent, Dr. Arakiki testified he trusts what respondent says and seeks him out for advice. He believed respondent’s judgment was excellent and he was honest and very helpful. He testified everyone in the medical group respected respondent’s integrity and abilities. In addition, patients have expressed satisfaction to him about respondent’s care.

48. Respondent submitted a number of letters from other physicians and patients describing the high quality of care he provided to patients.

Costs

49. For the investigation and enforcement of this matter, the Board incurred Attorney General’s costs in the amount of $23,839.75, investigative services costs in the amount of $7,624.27, and expert reviewer costs in the amount of $6,985.00. The total is $38,449.02. The amount is reasonable.

LEGAL CONCLUSIONS

1. In this proceeding, complainant bears the burden of establishing the charges by clear and convincing evidence to a reasonable certainty. Ettinger v. Board of Medical Quality Assurance (1982) 135 Cal.App.3d 853. This requires the evidence be "of such convincing force that it demonstrates, in contrast to the opposing evidence, a high probability of the truth" of the charges (BAJI 2.62), and to be "so clear as to leave no substantial doubt." In re Angelia P. (1981) 28 Cal. 3d 908, 919; In re David C. (1984) 152 Cal.App.3d 1189, 1208. If the totality of the evidence serves only to raise concern, suspicion, conjecture or speculation, the standard is not met.
2. The First Cause for Discipline of the Second Amended Accusation alleges respondent committed gross negligence and repeated negligent acts, and was incompetent in violation of Business and Professions Code section 2234, subdivisions (b), (c), and (d), in connection with his care and treatment of Lois M. in a number of respects. Based upon the determination that Dr. Soudajain’s testimony was more persuasive and his opinions were more reasonable and objective than those of Dr. Khan (Factual Findings 39 and 41), it must be concluded respondent committed repeated acts of negligence, was grossly negligent, and incompetent as follows:

A. It is alleged respondent misdiagnosed Lois M. as having follicular lymphoma, a low grade lymphoma, when in fact, she suffered from diffuse lymphoma, an intermediate grade lymphoma, and treated her inappropriately because of the misdiagnosis. Respondent’s chart notes clearly show he made the diagnosis of a low grade follicular lymphoma on October 9 at a time when he had the results of the needle biopsy but not the results of the excisional biopsy. Although he knew on October 9 that an excisional biopsy had been done, his chart shows that on every visit thereafter, respondent never changed the diagnosis to an intermediate grade, diffuse mixed small and large cell, focally follicular, as found by Dr. Hernandez. There is nothing in the chart to suggest respondent appreciated Dr. Hernandez’ report between the time of the first visit on October 9 and the conclusion of the four cycles of chemotherapy in January. The standard of care required him to consider the pathology report. His failure to do so violated the standard of care and was negligent.

Respondent treated Lois M. based on his misdiagnosis of low grade lymphoma. The standard of care required him to take the results of the excisional biopsy into account in deciding on a treatment regime. Since he did not have the results on October 9, but knew an excisional biopsy had been done, he should have waited until he received the report before beginning treatment. His decision to proceed with treatment without the report of the excisional biopsy violated the standard of care and was negligent.

Respondent treated Lois M. with a single agent chemotherapy, fludarabine, based on his misdiagnosis of a low grade lymphoma. This resulted in sub-optimal treatment. A more aggressive treatment regime was necessary to treat the patient’s intermediate grade lymphoma, and that would have consisted of multiple chemotherapy agents. Respondent’s decision to treat Lois M. only with fludarabine was a violation of the standard of care and was negligent.

B. It is alleged respondent failed to follow-up on the CT findings of pleural effusion. The CT scans of Lois M.’s chest were part of the staging evaluation. The first finding on September 24 was of a small right pleural effusion but on October 26, after the first cycle of chemotherapy had been administered, the finding was of a moderate pleural effusion. The standard of care required respondent to investigate the pleural effusion for the presence or absence of lymphoma in the pleura. Presence of lymphoma in the pleura could have changed the staging determination and could result in different treatment. Respondent did not consider the pleural effusion in staging of her disease. Respondent’s failure to follow-up on the findings of pleural effusion was below the standard of care and was negligent.
C. It is alleged respondent failed to note on the August 6, 1999 prescription for prednisone that it was to be taken only for five days. The standard of care required him to both explain to the patient that she was to take the medication for five days and provide that information on the prescription. Because he did not do that, Lois M. took the medication for 20 consecutive days. Respondent’s failure to write down on the prescription the number of days the patient was to take the prednisone was a departure from the standard of practice and was negligent.

D. It is alleged respondent failed to monitor the side effects of the prednisone on Lois M.’s diabetes. Respondent knew the patient suffered from diabetes and he should have been aware of her medical history relating to diabetes as shown in her chart. Prednisone can exacerbate diabetes. Among the concerns would have been increased hyperglycemia, psychosis, salt and water retention, and gastric acidity. The degree of the risk is determined by the severity of the diabetes and how well it was controlled. Respondent should have known the patient did not have a history of controlling her diabetes well. He should have obtained a blood sugar level but did not. Respondent’s failure to monitor the side effects of the prednisone Lois M. was taking was below the standard of care and was negligent.

E. It is alleged respondent failed to evaluate Lois M. for her rising creatinine and BUN as well as her renal failure on August 20, 1999. Renal failure is a frequent complication from uncontrolled diabetes but respondent did not do anything. He should have considered the rising creatinine and BUN results but did not do so. This failure violated the standard of care and was negligent.

F. It is alleged that on August 27, 1999, respondent failed to obtain blood sugar and electrolytes levels. It was on that day that respondent learned Lois M. had been taking large doses of prednisone for twenty days instead of five. He knew she was a diabetic and it was not controlled. He knew she was confused and there was a change in the level of consciousness. He should have either obtained a blood sugar and electrolytes or alerted her primary care physician that Lois M. had been taking prednisone for twenty days. It was not enough for him to simply tell her to discontinue the prednisone and return in a week.

Respondent’s failure to act appropriately between August 6 and August 27, as set forth above, was an extreme departure from the standard of care and was gross negligence.

G. Respondent’s failure to consider the final report of the excisional biopsy which caused him to treat Lois M. inappropriately, his failure to investigate the change in the patient’s pleural effusion, his failure to record on the prescription the number of days Lois M. was to take the prednisone, and his failure to take the appropriate steps between August 6 and August 27, 1999, demonstrated incompetence.

3. The Second Cause for Discipline of the Second Amended Accusation alleges respondent committed gross negligence and repeated negligent acts, and was incompetent in
violation of Business and Professions Code section 2234, subdivisions (b), (c), and (d), in connection with his care and treatment of William E. Based upon the determination that Dr. Soudajain’s testimony was more persuasive and his opinions were more reasonable and objective than those of Dr. Khan (Factual Findings 39 and 41), it must be concluded that respondent committed repeated acts of negligence, as follows:

A. It is alleged respondent failed to withhold chemotherapy on May 29 1998 despite the fact there was no evidence William E.’s performance status had improved.

Respondent acted appropriately and within the standard of care when he withheld the fifth cycle of chemotherapy from William E. on April 10, May 8, and May 22, 1998. The patient was wheelchair-bound and his performance status was poor. He had undergone four cycles of chemotherapy and was weakened to the point where he had to be hospitalized for the side effects of chemotherapy. After he broke his hip and was recovering from that injury, and was still in a weakened condition, continued chemotherapy had the potential to be lethal. Chemotherapy is toxic, and while it is a life-saving procedure, the patient has to be strong enough to withstand it. However, William E. was not eating well, needed assistance with the activities of daily living, and was completely bedridden. His performance which caused respondent to appropriately withhold chemotherapy did not improve between May 22 and May 29 except his cough had improved.

The standard of practice required respondent to continue to withhold chemotherapy on William E. The patient was recovering from a hip fracture. The presence of a cough is a good reason to withhold chemotherapy since the cough could indicate a lung infection, but the absence of a cough is not an indication that performance has improved, particularly where the patient is bedridden. Chemotherapy had been withheld for about seven weeks and as of April 10, according to respondent, the patient had undergone near complete response. Rather than submit this weakened patient to another cycle of chemotherapy, respondent could have repeated some of the staging studies if he was concerned about whether the patient had a significant response. If those studies showed some evidence of lymphoma, that might have been a justification for continuing chemotherapy in spite of his poor performance status.

Respondent’s decision to administer the fifth cycle of chemotherapy to William E. on May 29, 1998 was below the standard of care and was negligent.

B. It is alleged respondent failed to withhold chemotherapy on June 19, 1998 despite the fact there was no evidence William E.’s performance status had improved, and he presented with evidence of dehydration.

The same considerations that required respondent to withhold chemotherapy on May 29 required him to withhold chemotherapy on June 19. The patient’s performance status had not improved. In fact, he was worse. He complained of a dry cough and his white count was elevated. It had never been elevated before. His blood pressure was relatively low, particularly for a patient suffering from hypertension. Given that the patient had already received five cycles of chemotherapy, respondent should have considered infection and
dehydration. Based on these considerations, plus the fact that the patient’s performance status had not improved, respondent should have withheld chemotherapy. Respondent’s decision to administer the sixth cycle of chemotherapy to William E. on June 19, 1998 was below the standard of care and was negligent.

4. The Third Cause for Discipline of the Second Amended Accusation alleges respondent committed gross negligence and repeated negligent acts, and was incompetent in violation of Business and Professions Code section 2234, subdivisions (b), (c), and (d), in connection with his care and treatment of Dorothy D. in a number of respects. Because respondent relied to a substantial degree on the testimony of Dr. Yang and Dr. Beutler, a different analysis is required.

Respondent was only one of several physicians who undertook Dorothy D.’s care. Her primary care physician for the most part relevant to this case was Dr. Morgenstern. Respondent’s role was limited to the management of her iron deficiency anemia. By the time respondent entered the picture, Dr. Morgenstern had referred her to the GI department for a workup to determine the cause of her GI bleeding. Respondent, as a hematologist/oncologist, obviously had nothing to do with that aspect of her care.

Dorothy D. had a long-standing history of iron deficiency anemia. It was first documented in 1998, and she had received incomplete and ineffective workups. Thus, when respondent first saw her on January 5, 2000, she had already been referred to the GI department for a colonoscopy. According to Dr. Yang, a proper workup in 1998 or 1999 could have resulted in the discovery of the cancer, and he based that opinion on the size of the tumor when it was discovered and the relatively slow rate at which such tumors grow. In any event, by 2000, this patient, with her history, should have been given a high priority for a colonoscopy, and it was the responsibility of the GI department to do that. Both Dr. Yang and Dr. Beutler correctly criticized the GI department for failing to perform a colonoscopy in a timely fashion.

A. It is alleged respondent failed to establish whether Dorothy D. had a correctable disease process in her gastrointestinal tract which was causing her to have chronic iron deficiency anemia associated with bleeding from the GI tract prior to treating her with IV iron therapy. In Dr. Soudajian’s opinion, there should have been a very clear indication for IV iron therapy because it is a more dangerous therapy than oral therapy. The primary concern was a severe anaphylactic reaction that can lead to respiratory arrest, and required that the medication be used with caution in patients with a history of significant allergies and/or asthma. Dr. Soudajian believed it was an extreme departure from the standard of care for respondent to begin IV iron therapy on Dorothy D. before determining the cause of the GI bleeding and determining if the cause was correctable.

Dr. Beutler testified that in 2000-02, iron dextran was the major drug used to treat iron deficiency anemia, but it carried risks such as transient fever and arthralgia as well as anaphylaxis which can cause death. He testified investigators had determined the risk of death to be 1.2 deaths per million dosages. However, he had not seen any reports of increased risk in patients with allergies and asthma. He did not believe a warning to this
effect on a package insert was of much value in deciding whether the medication ought to be used.

In Dr. Beutler’s opinion, IV iron was a therapy regardless of whether the source was correctable. Dorothy D. needed iron dextran to treat her iron deficiency and that was the primary consideration from respondent’s point of view. His alternative was transfusions, but in Dr. Beutler’s opinion, transfusions posed greater risks and higher morbidity than IV iron. He believed it would have been inappropriate not to give the IV iron and subject the patient to transfusions, and it should have been given while the patient was being worked up to determine the cause of her bleeding. He reasoned that a doctor cannot withhold treatment if that endangered the patient.

Dr. Beutler’s opinion makes sense. The GI department had failed in two years to determine the cause of Dorothy D.’s bleeding and after receiving oral iron, Dorothy D. was still anemic. Respondent needed to do something, and he chose the best course available to him. In addition, he administered the IV iron cautiously and in accordance with the suggested method of administering the medication, with a small test dose given first, followed by the balance of the medication if the test was successful, and it was administered in a hospital setting.

It cannot be concluded that respondent departed from the standard of care when he administered IV iron to Dorothy D. before the cause of her GI bleeding had been determined.

B. It is alleged respondent failed to document that Dorothy D. was informed about the possibility that her asthma might be dangerously exacerbated with IV iron therapy. According to Dr. Beutler, he had not seen anything in the literature that indicated there were increased risks to patients with asthma who received IV iron dextran, and he had never heard such a claim from any of his colleagues. Dr. Beutler’s knowledge about such matters in this field is truly impressive, and it is appropriate to rely on his views. Accordingly, respondent did not depart from the standard of care regarding any warning about the dangers associated with IV iron therapy to a patient with asthma.

C. It is alleged respondent failed to document that he made sufficient attempts to expedite the colonoscopy by explaining the reasons for the urgency and failed to request a formal GI consultation when it became apparent the colonoscopy was being delayed for months. There can be no question that Dorothy D. deserved to have a colonoscopy performed and it should have been done immediately after Dr. Morgenstern sent the referral to the GI department in December 1999. Respondent as the hematologist managing the patient’s iron deficiency anemia did not have the responsibility of determining the cause of the bleeding. The issue is whether the GI department’s failure to perform the colonoscopy in a timely fashion should be attributed in some way to respondent.

The issue raises the question of how medical care is organized. The overall care of Dorothy D. fell on Dr. Morgenstern as her primary care physician, and part of that care required him to refer the patient for a GI workup and then expedite the workup in light
of her symptoms. The testimony of Dr. Beutler, Dr. Yang, and Dr. Khan make it clear that respondent’s role as a consultant managing the patient’s iron deficiency anemia did not include pushing the GI department to do the appropriate workup. Their testimony is reasonable and makes sense. Nevertheless, after several months of waiting, respondent did take a step toward having her worked up by having her admitted to the Adult Holding Unit. Yet that effort failed as well. Under these circumstances, it is unfair to hold respondent responsible for the failure of the GI department to perform its job. Respondent therefore did not depart from the standard of care.

D. It is alleged respondent failed to consider evaluating the remainder of the GI tract in case her colonoscopy turned out to be negative, and planned instead to evaluate her urologically or gynecologically. In addition, respondent is criticized for not carrying out his plan to have Dorothy D. evaluated urologically or gynecologically once the colonoscopy turned out to be negative, and never considered asking that the remainder of the GI tract be evaluated.

Respondent’s consultation note to Dr. Morgenstern recommended additional methods of investigation. Respondent as the hematologist managing the patient’s iron deficiency anemia did not have the responsibility of ordering evaluations in other areas. Dr. Morgenstern had that responsibility. Nor did respondent have the responsibility of telling a gastroenterologist how to perform a GI workup. Once Dorothy D. was referred to the GI department, the doctors in that department had the responsibility of taking all appropriate steps to determine the cause of her bleeding if indeed the cause was in her GI tract. The testimony of Dr. Beutler, Dr. Yang, and Dr. Khan support the conclusion that respondent did not violate the standard of care in this respect.

E. It is alleged respondent failed to order additional tests such as vitamin B-12 and folic acid to determine whether Dorothy D. had a problem with poor iron absorption of iron which lead to her iron deficiency anemia. According to Dr. Beutler, the standard of care did not require these tests be performed after the colonoscopy came back negative. The patient was bleeding from her GI tract and there were no other reasonable considerations. His testimony was persuasive that these tests were unnecessary, and therefore respondent did not violate the standard of care.

5. The Fourth Cause for Discipline of the Second Amended Accusation alleges respondent failed to maintain adequate and accurate records in connection with his care and treatment of Lois M., William E., and Dorothy D. Clearly, respondent’s failure to document the correct diagnosis of Lois M. was a failure in this regard. Likewise, respondent failed to document William E.’s performance status, and in particular, a sufficiently objective performance status that would have justified resumption of chemotherapy after respondent had withheld it. Respondent’s records regarding Dorothy D. were satisfactory.

6. The Fifth Cause for Discipline of the Second Amended Accusation alleges respondent knowingly made or signed documents related to the practice of medicine which falsely represented the existence or nonexistence of a state of facts in connection with the diagnosis, care, and management of Lois M. This charge relates to respondent’s diagnosis of
low grade in light of the pathology reports of the excisional biopsy which showed the lymphoma to be an intermediate grade lymphoma.

Respondent testified he reviewed Dr. Hernandez’ report, did not agree with it, and spoke to him on several occasions, and spoke to Dr. Azizi as well. His testimony was not credible and was rejected. See Factual Findings 44 and 45. That means respondent either received the reports and misinterpreted or misunderstood them, or never saw them in the first place. In order to find respondent knowingly created false documents, the evidence would have to establish that respondent read and considered the pathology reports of the excisional biopsy and despite the conclusions set forth in them, decided to document an incorrect diagnosis in his records. While that is a possible interpretation, it by no means was established by clear and convincing evidence to a reasonable certainty. It is just as likely that respondent overlooked the pathology reports of the excisional biopsy since they were prepared after he started treatment. Accordingly, it must be concluded the evidence did not establish respondent knowingly made false documents.

7. The Sixth Cause for Discipline of the Second Amended Accusation alleges respondent was dishonest when he testified at the hearing as he did regarding the diagnosis of Lois M.

A trier of fact may consider “any matter that has any tendency in reason to prove or disprove the truthfulness” of a witness at a hearing. (Evid. Code § 780.) Respondent’s testimony was not credible for a number of reasons, including the unreasonableness of it, the lack of documentation to support his claim, his demeanor, his reluctant admission that he made a mistake, and his failure to mention these conversations during his interview with the Board’s investigators and at his deposition. However, that is a far cry from clear and convincing evidence to a reasonable certainty that respondent was dishonest. There was no direct evidence, for example, that specifically contradicted his testimony that he spoke to Dr. Hernandez. Dr. Hernandez did not testify, and submitted a hearsay declaration in which he wrote he did not recall speaking to respondent, but that declaration must be given little weight since he did not testify and the alleged discussions occurred nearly seven years ago. Thus, the only evidence to support the charge of dishonesty are reasonable inferences drawn from circumstantial evidence, and while that is sufficient for a trier of fact to disbelieve a witness, such evidence is not clear and convincing evidence to a reasonable certainty to establish respondent was dishonest. The charge must fail.

8. The Seventh Cause for Discipline of the Second Amended Accusation alleges respondent committed general unprofessional conduct in connection with the diagnosis of Lois M. It is related to the Sixth Cause for Discipline and depends on a determination that respondent acted dishonestly when he testified. Since it was not established by clear and convincing evidence to a reasonable certainty that respondent acted dishonestly when he testified at the hearing, this charge must fail as well.

9. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234, subdivision (b), gross negligence in connection with his care
and treatment of Lois M., was established by reason of Findings 4-14 and 39-41, and Legal Conclusion 2F.

10. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234, subdivision (d), incompetence in connection with his care and treatment of Lois M., was established by reason of Findings 4-14, and 39-41, and 44-45, and Legal Conclusion 2A-G.

11. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234, subdivision (c), repeated negligent acts in connection with his care and treatment of Lois M., was established by reason of Findings 4-14, 39-41, and 44-45 and Legal Conclusion 2A-F.

12. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234, subdivision (c), repeated negligent acts in connection with his care and treatment of William E., was established by reason of Findings 15-25 and 39-41, and Legal Conclusion 3A and B.

13. Cause for discipline of respondent's license for violation of Business and Professions Code sections 2234, subdivision (b), gross negligence, and 2234, subdivision (d), incompetence, in connection with his care and treatment of William E., was not established.

14. Cause for discipline of respondent's license for violation of Business and Professions Code sections 2234, subdivision (b), gross negligence, 2234, subdivision (c), repeated negligent acts, and 2234, subdivision (d), incompetence, in connection with his care and treatment of Dorothy D., was not established by reason of Findings 23-37, 42, 43, and 46, and Legal Conclusion 4A-E.

15. Cause for discipline of respondent's license for violation of Business and Professions Code section 2266, failure to maintain accurate and adequate records, was established by reason of Findings 4-25 and 39-41 and Legal Conclusion 5.

16. Cause for discipline of respondent's license for violation of Business and Professions Code section 2261, knowingly making false documents, was not established by reason of Legal Conclusion 6.

17. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234, subdivision (e), dishonesty, was not established by reason of Legal Conclusion 7.

18. Cause for discipline of respondent's license for violation of Business and Professions Code section 2234, unprofessional conduct, was not established by reason of Legal Conclusion 8.

19. Cause to require respondent to reimburse the Board for its costs of investigation and prosecution of this matter pursuant to Business and Professions Code
section 125.3 was established. However, the amount must be reduced because complainant failed to establish respondent violated the Medical Practice Act in connection with his care and treatment of Dorothy D. Based on the evidence introduced at the hearing and the amount of time devoted to the charges relating to Dorothy D., it is reasonable to conclude that the case involving Dorothy D. constituted one-third of the entire case brought against respondent. Accordingly, the amount of investigation and prosecution costs must be reduced by that amount, from $38,449.02 to $25,760.84.

20. Respondent argues that laches applies to the Lois M. and William E. cases. For laches to apply, the burden is upon respondent to establish the delay was unreasonable and caused him to be prejudiced. Fahmy v. Medical Board of California (1995) 38 Cal.App.4th 810; Lam v. Bureau of Collection (1995) 34 Cal.App.4th 29; Gates v. Department of Motor Vehicles (1979) 94 Cal.App.3rd 921, 925. In Lam, the court held a delay of three years between discovery of the facts and the filing of the accusation did not warrant dismissal of the charges on the ground of laches because the licensee did not establish prejudice. In contrast, in Gates, a delay of less than 16 months was not justified, and the licensee established prejudice. The Court of Appeal upheld the trial court's dismissal of the accusation on the ground of laches.

Respondent presented no evidence to establish a delay was unreasonable or he was prejudiced. The record does not show when the Board learned of the cases involving Lois M. and William E. or when it started its investigations. There were apparently civil actions brought in those matters, but the record does not indicate whether the Board learned of the cases through a report of a settlement, award, or judgment, or a consumer complaint. Thus, the only information in the record are the dates of the events which occurred in 1998 and 1999, and the date the original accusation was filed, December 2, 2003. That is insufficient to determine if there was a delay.

In addition, respondent did not establish prejudice. He points to Dr. Hernandez' inability to recall the Lois M. case and the absence of his original report in the Kaiser Fontana chart as evidence of prejudice. Dr. Hernandez did not testify and submitted two declarations, one for each side. His report was introduced into evidence and dissected by several witnesses. His testimony about his findings would have added little, if anything. There is no reason to believe any delay caused his report not to be in the Kaiser Fontana chart. Likewise, there is no reason to believe any delay caused lab information not to be in William E.'s chart. All three cases were based on voluminous amounts of information, and expert interpretation of them. Respondent's claim of laches is without merit.

21. In order to properly assess the penalty to be imposed in this case, factors in mitigation and aggravation must be considered and weighed. In mitigation, this is the first disciplinary action brought against respondent and it involves only two patients. Respondent's treatment of the two patients occurred six and seven years ago. He is board-certified and was recently recertified. He is well-respected by other physicians and patients.

In aggravation, respondent expressed no remorse for his conduct, even though two of his patients died. He was unwilling to admit he made any mistakes other than a failure to
correctly document his diagnosis of Lois M. The most aggravating matter, however, was respondent's false testimony regarding his diagnosis of Lois M.

For violations of Business and Professions Code section 2234, subdivisions (b), (c), and (d), the Board's Disciplinary Guidelines call for a revocation, stayed, a five-year period of probation and terms and conditions tailored to the violations that were established. In this case, the factors in aggravation outweigh the factors in mitigation, and require that the period of probation be increased from five years to seven years, and respondent receive an actual suspension. The thrust of this case was respondent's care and treatment of Lois M. and William E. That must be addressed. The other charges are minor ones and do not require imposition of additional penalties.

ORDER

Physician's and surgeon's certificate number A 52005 issued to respondent Sunil Patel, M.D., is hereby revoked. However, the revocation is stayed and respondent is placed on probation for seven (7) years on the following terms and conditions:

1. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision, Accusation, and any other information that the Division or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Division or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not
respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent’s initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

After respondent has successfully completed the clinical training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include 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, or until the Division or its designee determines that further participation is no longer necessary.

Failure to participate in and complete successfully the professional enhancement program outlined above is a violation of probation.

2. **Education Course**

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Division or its designee for its prior approval an 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 1 certified, limited to classroom, conference, or seminar settings. 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 Division 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.

3. **Monitoring - Practice**

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Division 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 Division, 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 Division 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.

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.

The monitor(s) shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent’s performance, indicating whether respondent’s practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Division 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 5 calendar days of such resignation or unavailability, submit to the Division 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 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, 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.
Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

4. Ethics Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in ethics, at respondent’s expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation.

An ethics 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 Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division 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 Division 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.

5. 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, at respondent’s expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

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 Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division 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 Division 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.

6. Oral and/or Written Examination

Within 60 calendar days of the effective date of this Decision, respondent shall take and pass an oral and/or written examination, administered by the Probation Unit. The Division or its designee shall administer the oral and/or written examination in a
subject to be designated by the Division or its designee and the oral examination shall be audio tape recorded.

If respondent fails the first examination, respondent shall be allowed to take and pass a second examination, which may consist of an oral and/or written examination. The waiting period between the first and second examinations shall be at least 90 calendar days.

Failure to pass the required oral and/or written examination within 180 calendar days after the effective date of this Decision is a violation of probation. Respondent shall pay the costs of all examinations. For purposes of this condition, if respondent is required to take and pass a written exam, it shall be either the Special Purpose Examination (SPEX) or an equivalent examination as determined by the Division or its designee.

Respondent shall not practice medicine until respondent has passed the required examination and has been so notified by the Division or its designee in writing. This prohibition shall not bar respondent from practicing in a clinical training program approved by the Division or its designee. Respondent’s practice of medicine shall be restricted only to that which is required by the approved training program.

7. Actual Suspension

As part of probation, respondent is suspended from the practice of medicine for 60 (sixty) days beginning the sixteenth (16th) day after the effective date of this decision.

8. Notification

Prior to engaging in the practice of medicine the respondent shall provide a true copy of the 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 Division or its designee within 15 calendar days.

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

9. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.
10. **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.

11. **Quarterly Declarations**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, 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.

12. **Probation Unit Compliance**

Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

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

13. **Interview with the Division or its Designee**

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

14. **Residing or Practicing Out-of-State**

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.
All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside 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; Probation Unit Compliance; and Cost Recovery.

Respondent’s license shall be automatically cancelled if respondent’s periods of temporary or permanent residence or practice outside California totals two years. However, respondent’s license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

15. Failure to Practice Medicine - California Resident

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent’s license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

16. Completion of Probation

Respondent shall comply with all financial obligations (e.g., cost recovery, 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.
17. 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 Division, 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 Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

18. Cost Recovery

Within 90 calendar days from the effective date of the Decision or other period agreed to by the Division or its designee, respondent shall reimburse the Division the amount of $25,760.84 for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve the respondent his/her obligation to reimburse the Division for its costs.

19. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent’s license. The Division reserves the right to evaluate respondent’s request and to exercise its discretion 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 Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent’s license shall be deemed disciplinary action.

If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.
20. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

DATED: 8/5/05

ALAN S. METH
Administrative Law Judge
Office of Administrative Hearings