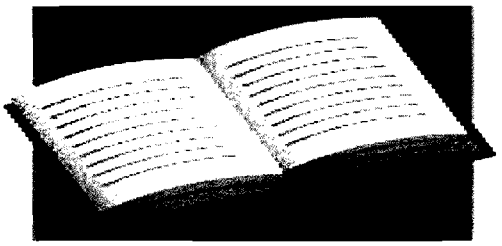
MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM

EXPERT REVIEWER GUIDELINES

(revised January, 2009)



District Offices
contact information

Cerritos 12750 Center Court Drive South, Suite 750 Cerritos CA 90703 Tel.: 562/402-4668; Fax 562/865-5247	**Diamond Bar** 1370 S. Valley Vista Drive, Suite 240 Diamond Bar, CA 91765 Tel: 909/396-5305; Fax 909/396-5313
Fresno 5070 N. Sixth Street, Suite 105 Fresno, CA 93710 Tel.: 559/221-0558; Fax 559/221-0297	**Glendale** 320 Arden Avenue, Suite 250 Glendale, CA 91203 Tel: 818/551-2117; Fax 818/551-2131
Pleasant Hill 3478 Buskirk, Suite 217 Pleasant Hill, CA 94523 Tel: 925/937-1900; Fax 925/937-1964	**Rancho Cucamonga** 9166 Anaheim Place, Suite 110 Rancho Cucamonga, CA 91730 Tel: 909/476-7146; Fax 909/476-7213
Sacramento 2535 Capitol Oaks Drive, Suite 220 Sacramento, CA 95833 Tel: 916/263-2585; Fax 916/263-2591	**San Bernardino** 464 West 4th Street, Suite 429 San Bernardino, CA 92401 Tel: 909/383-4755; Fax 909/383-4172
San Diego 4995 Murphy Canyon Road, Suite 203 San Diego, CA 92123 Tel. 858/467-6830; Fax 858/467-6836	**San Jose** 1735 Technology Drive, Suite 800 San Jose, CA 95110 Tel: 408/437-3680; Fax 408/437-3693
Tustin 15641 Redhill Avenue, Suite 215 Tustin, CA 92780 Tel: 714/247-2126; Fax 714/247-2137	**Valencia** 27202 Turnberry Lane, Suite 280 Valencia, CA 91355 Tel: 661/295-3397; Fax 661/295-3030
Special Investigations Unit 2005 Evergreen St., Suite 1200 Sacramento, CA 95815 916/263-2517	

Expert Reviewer Program
320 Arden Avenue, Suite 250, Glendale, CA 91203 Tel. (818) 551-2129; Fax (818)551-2131

TABLE OF CONTENTS

GUIDELINES

Mission Statement ..... page 1

Introduction ..... page 1

Most Frequently Asked Questions ..... page 3

Investigations and the Disciplinary Process ..... page 6

Types of Evaluations ..... page 12

Expert Review Instructions ..... page 20

Expert Review Checklist ..... page 23

The Opinion Itself ..... page 24

Sample Reports ..... pages 31,37,41,46

Compensation ..... page 51

The Medical Board of California

MISSION STATEMENT

The mission of the Medical Board of California is to protect healthcare consumers through proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

INTRODUCTION

The Medical Board of California (hereafter referred to as Board) is a state regulatory agency within the Department of Consumer Affairs.

The Board is responsible for investigations and discipline of physician licensees of the State of California. The primary purpose of the Board is to protect the public from incompetent, negligent, dishonest and/or impaired physicians. Your role as an objective expert reviewer is extremely important in identifying whether a departure from the accepted standard of care has occurred, thereby constituting unprofessional conduct. You will also be called to serve as an expert witness at any administrative hearing or criminal proceeding that may result from your expert opinion.

The purpose of this manual is to describe the administrative disciplinary process for physician misconduct and to define the expectations of the Board with respect to your review.

As an expert reviewer, initially you will be provided medical records and other information concerning an investigation. This may include reports which contain interviews of patients, subsequent treating physicians, other witnesses, and the physician who is the subject of the investigation. You will be asked, on the basis of your review of the documentation provided, to render your impartial opinion of the care provided by the subject physician.

Your objective opinion must be based solely upon the information provided to you by the Board; however, you may refer to peer review journal articles, medical texts and other authoritative reference materials which help to define the accepted standard of care. The opinion should be based upon your knowledge of the accepted standard of care, drawing from your education, training, experience and knowledge of the medical literature. **Because of laws protecting confidentiality, you may not discuss the case with anyone other than staff of the Medical Board and the Attorney General. Please Note: While you may discuss the case with staff of the Medical Board, you may not discuss the case with any of the 15 Board Members, as they need to remain**

impartial.

Submitting a case for expert review does not imply that there are departures from the standard of care. You will be provided with the medical issues to be addressed for each case. You will discuss the standard of care for each medical issue and articulate an analysis and explanation of your conclusions (either no departure, simple departure, extreme departure, and/or lack of knowledge). Feel free to address other medical issues that you come across during your review.

If you have prior knowledge of the subject physician/other parties involved or if you feel you cannot be objective in your review for any reason, please inform the MBC Investigator assigned to the case and do not accept the case for review. It is also very important to make sure that you have experience with the procedure or treatment at issue during the time frame of the alleged misconduct.

You will be required to testify in administrative hearings held before an administrative law judge for those cases that progress to a hearing. In these instances, you will be considered an expert witness and will be required to meet with the Deputy Attorney General, assigned to prosecute the case, prior to the hearing. The purpose of the meeting is to prepare your testimony for the hearing.

The Medical Board of California greatly appreciates your willingness to serve as an expert reviewer. You play a vital role to the Board in its mission of public protection.

MOST FREQUENTLY ASKED QUESTIONS

☐ **Will I have to testify?**

If the case is submitted for disciplinary action, and no stipulated agreement is reached, you will be called upon to provide expert testimony. A stipulated agreement means that both parties have reached an agreement as to what discipline, if any, will be given in the matter. However, at present approximately 70% of cases are settled without a hearing.

☐ **Can I be sued for expressing my opinion?**

Civil Code §43.8 provides immunity from civil liability for expert reviewers. While in theory one could be sued for expressing an opinion as an expert reviewer, such lawsuits are exceedingly rare. In addition, the Attorney General's office would defend such suits.

☐ **Can I do some research?**

Yes, you may consult peer-reviewed journal articles, medical texts and other authoritative reference materials which help define accepted standards. Please cite or identify any and all references used in your written opinion. It is important that you do not attempt to conduct your own investigation. You cannot contact or discuss the case with the patients, the subject physician, other physicians, Board members, or anyone else. You must scrupulously protect the confidentiality of the subject of the case, and the patients involved.

☐ **What if I need additional information or clarification?**

Contact the Medical Board Investigator assigned the case as soon as possible and request whatever additional information you need to complete your review. Do not contact any outside witnesses or sources.

☐ **How soon do I need to complete the review and provide an opinion?**

You are allowed 30 days. In a complicated case, involving multiple patients, your review could extend beyond our 30-day time frame, but no more than 60 days. Keep in mind that the physician under review will continue to see patients until a determination is made by the Board. If you feel this physician poses a danger to patients, it is vital that you inform Medical Board staff ***immediately***, and provide your opinion expeditiously, in order to protect the public.

If you find your background is not suited to review a particular case, or other commitments preclude you from meeting the deadline, or, for any reason, you need to be excused from a case

(e.g., to avoid potential conflict of interest) immediately notify the MBC Investigator assigned to the case.

☐ **Who will see my report?**

The subject physician will be provided with a copy of your report as part of legal discovery if an accusation is filed. **Please be aware that once a case proceeds to an administrative hearing, and rarely, to criminal proceedings, through legal discovery, the information, including your report, may become public record**. Public disclosure of medical expert reports, however, occurs rarely.

Your report, without personal identifiers, may be shared with the subject as an educational tool in cases that do not proceed to formal discipline.

☐ **Can you give me a copy of a sample report?**

Yes, see pages 31-50

☐ **What is the difference between a simple departure and an extreme departure from the standard of practice?**

The "standard of care" (also referred to as the "standard of practice") for general practitioners is defined as that level of skill, knowledge, and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent physicians in the same or similar circumstances at the time in question.

Specialists, such as anesthesiologists and ophthalmologists, are held to that higher standard of skill, knowledge and care ordinarily possessed and exercised by other reasonably careful and prudent specialists in the same or similar circumstances at the time in question.

Negligence is the failure to use that level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful physicians would use in the same or similar circumstances. A negligent act is often referred to as a "**simple departure**" from the standard of care.

Gross negligence, on the other hand, is defined as "the want of even scant care" or "an **extreme departure** from the standard of care." Gross negligence can be established under either definition, both are not required. The difference between gross negligence and ordinary negligence is the degree of departure from the standard of care.

☐ **What is incompetency?**

Incompetency is generally defined as "an absence of qualification, ability or fitness to perform a prescribed duty or function." (Pollack v. Kinder (1978) 85 Cal.App.3d 833, 837.) Do not use the term incompetence to describe a departure from the standard of practice, as they are not synonymous. Incompetence is synonymous with lack of knowledge. A physician may be

competent to perform a duty but negligent in performing that duty.

☐ **How much will I be paid?**

You will be compensated at the rate of $150.00 per hour for your evaluation and report. It is important that you advise the assigned investigator when you are approaching 10 hours of review. There are often complex, voluminous cases, that you will need more than 10 hours to complete your review. In those situations, it is not a problem to approve the extra hours, however, it must be done **prior** to incurring additional hours and **you must obtain approval from the investigator or district office supervisor.** Should you be required to provide testimony at a hearing you will be compensated at the rate of $200.00 per hour for a maximum of 8 hours or $1600.00 per day.

☐ **How soon will I be paid?**

Generally speaking, you should receive payment for your services within four to six weeks of submitting all required paperwork.

❑ The Role of the Board in Physician Discipline

The Medical Board of California, which is part of the State of California Department of Consumer Affairs, is responsible for investigating and bringing disciplinary action against the professional licenses of physicians and surgeons suspected of violations of the Medical Practice Act **(Business and Professions Code §2000, et seq.)**.

The Board's proceedings are conducted in accordance with the Administrative Procedure Act **(Government Code §11150 et seq.)**. Its investigations and hearings are conducted pursuant to **Government Code §11180 through §11191. Business and Professions Code §2001** establishes the Medical Board of California, which consists of 15 members, seven of whom are public members [non-physicians]. **Business and Professions Code §2004** defines the duties of the Board, which are:

- The enforcement of the disciplinary and criminal provisions of the Medical Practice Act;
- The administration and hearing of disciplinary actions;
- Carrying out disciplinary actions appropriate to findings made by the division or administrative law judge;
- Suspending, revoking, or otherwise limiting certificates after disciplinary actions;
- Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

The Board identifies and takes appropriate action against any licensee who is charged with unprofessional conduct. The purpose of the disciplinary process is to assure quality medical care to the residents of the State of California and to preserve high standards of medical practice in this jurisdiction.

■ Complaints against physicians

Business and Professions Code §109 and §325 require the Board to investigate complaints concerning its licensees.

Complaints come to the Board from many sources. Under ***Business and Professions Code §800 et seq.***, civil judgments, settlements or arbitration awards against a licensee must be reported to the Board by insurers; discipline by any professional peer review body (hospital, medical society, health care service plan) must be reported to the Board; coroners must report

any deaths that may be due to gross negligence by a physician; district attorneys must report felony criminal filings against a physician; and courts must transmit felony preliminary hearing transcripts involving a licensee. Many complaints are filed by patients or by other licensees concerned about the care rendered by another physician for a patient or patients.

- **Investigation of Complaints**

Complaints regarding quality of care are received and reviewed in the Board's Central Complaint Unit (CCU) in Sacramento by a medical consultant in the same specialty in which the subject was practicing. The CCU medical consultant determines whether the quality of care issues presented in the complaint and supporting documents warrant investigation. If the medical consultant determines the case merits investigation, it is sent to the appropriate district office of the Board.

❑ Investigators, District Medical Consultants, Deputy Attorneys General, and Expert Reviewers

The following are summaries of the roles of the main participants in the process of investigating and prosecuting medical disciplinary cases.

- **The Role of the Investigator**

Board investigators are peace officers, pursuant to California Penal Code Section 830.3, authorized to investigate complaints of alleged violations of law by obtaining facts, documents, and other supporting evidence. Investigators obtain information by interviewing complainants, witnesses, and licensed health care professionals. They obtain supporting documentation, such as medical records, witness statements, court documents, and prescriptions. All the information obtained is memorialized in an investigation report. They serve investigational subpoenas and search warrants to obtain evidence. In criminal cases, investigators can secure an arrest warrant.

Investigators work closely with the District Medical Consultants (DMC) and Deputy Attorneys General (DAG) in reviewing case materials and determining what additional records or information is needed and whether an expert review is necessary. Once an expert reviewer is selected the assigned investigator is the contact person for the expert. The investigator tracks cases sent out for review to ensure they are completed within the standard 30-day time limit. If a report is not received within that time, the investigator contacts the expert reviewer to determine the reason for delay.

If a violation is confirmed, the matter is referred to the Office of the Attorney General. A request is made by the Board to initiate an administrative action against the license. Investigators may also present certain confirmed violations to a District Attorney/City Attorney if there is sufficient evidence of criminal violations.

If the case is referred for either administrative or criminal action, the investigator submits an investigation report with all evidence, including the expert report. If an administrative hearing or a criminal trial is conducted, the investigator works with the DAG and/or Deputy District Attorney (DDA). This includes case preparation, additional investigation if needed and working with the DMC to secure additional expert reviews, if needed.

- **The Role of the District Medical Consultant (DMC)**

The DMC assists investigators with the case investigation. This includes review of the complaint, medical and pharmacy records, insurance and billing records, and other documents in the case file where medical knowledge is needed. They also participate with the investigator and assigned DAG in interviews with subject physicians.

The DMC, investigator, and DAG determine whether the case should be sent for expert review. After all the evidence has been obtained, including the subject interview, the DMC prepares a memorandum identifying medical issues for expert comment. The DMC identifies expert reviewers in the appropriate specialty and geographic area from the Board's database, and they or the assigned investigator will contact the expert to arrange for review of the case.

The DMC reviews the report prepared by the expert reviewer. When appropriate, he or she provides feedback to the reviewer to assist in future case reviews and reports. The DMC also prepares an evaluation of the performance of the expert reviewer when the case is completed.

The DMC sets up professional competency examinations pursuant to a petition to compel a professional competency examination, or pursuant to a disciplinary order adopted by the Board. He or she may call upon an appropriate medical expert reviewer to participate in the examination, and to collaborate with other examiners in developing appropriate oral questions.

In some cases, the Board may order a physician to undergo either a physical or a psychiatric examination by an expert reviewer. The DMC may contact you and ask you to perform such an examination and prepare a report.

- **The Role of the Deputy Attorney General (DAG)**

During the course of an investigation, Health Quality Enforcement (HQE) DAGs work closely with investigators and provide direction and advice in the accumulation of evidence necessary to advise the Board on legal matters such as whether a formal accusation should be filed against a licensee, a complaint should be dismissed for lack of evidence, or other appropriate legal action should be taken. HQE DAGs also seek and obtain temporary license suspension orders whenever a licensee's continued practice of medicine, in light of the alleged violation(s) of law, will endanger the public health, safety or welfare.

HQE DAGs carefully review evidence obtained during the investigation to determine whether it is sufficient to establish that a violation of law has occurred. This review includes a careful assessment of witness statements, medical records, and expert reviewer reports. In quality-of-care cases, DAGs sometimes contact the expert reviewer to discuss the technical medical issues addressed in the expert reviewer's report. Such contacts, which are generally conducted by telephone, are extremely important in helping the DAG understand the often complex medical issues and clarify any possible ambiguity in the expert reviewer's report.

Where warranted by the evidence, a formal accusation is filed against the physician. Most physicians request a hearing on the charges filed against them and, in those cases, a hearing is scheduled with the Office of Administrative Hearings. The vast majority of these disciplinary cases are settled prior to the hearing with a stipulated agreement. Obviously, where a case is settled, expert reviewer involvement will be minimal. However, in those cases that do not settle and, instead, go forward to a full hearing, expert involvement will be critical to the successful prosecution of the case.

Typically, once a hearing has been scheduled with the Office of Administrative Hearings, the DAG will contact the expert to confirm availability for the hearing dates set in the case. As a general rule, expert presence at the hearing will be required on one day only. However, in some instances, it may be required on more than one day. The expert may also be called back to testify a second time in the same case as a rebuttal witness in order to rebut testimony offered by the licensee and/or his/her own expert witness(es).

Defense counsel often submit defense expert reports. The DAG, in turn, will often forward those defense expert reports to the expert for consideration and, most importantly, to determine whether the opinions expressed by defense experts in any way changes the original expert opinions given in the case.

In preparation for an upcoming hearing, the DAG will often contact the expert reviewer in order to schedule a face-to-face meeting to review the evidence in the case, the expert report, and opinions, as well as any possible defenses in the case. At the hearing, it is extremely important that the often complex medical issues be presented in terms that are clear, concise and readily understandable to the Administrative Law Judge assigned to hear the case, as the ALJ is not a medical professional.

In most instances, expert testimony at the administrative hearing will end the expert's involvement in the case. Following issuance of a final decision by the Medical Board, HQE DAGs will defend those decisions at both the superior court and appellate level. However, appeals are based on the record of the administrative hearing, including the transcripts and exhibits or other evidence. Witnesses are not called to testify in those proceedings.

■ The Role of the Expert Reviewer

The expert reviewer plays a crucial part in the investigation process by providing an objective, reasoned, and impartial evaluation of the case. **They are neither an advocate for the Board nor an advocate for the physician. Rather, the review is concerned primarily with whether there is a departure from the accepted standard of practice.**

An expert reviewer to the Board is expected to safeguard both the confidentiality of the records the identities of the patients, complainants and physicians involved. The expert reviewer is obligated not to divulge any information contained in the relevant medical records and investigations materials that are provided for review to other parties, at any time. Once the report is written, all case material must be returned to the Medical Board. The obligation to preserve confidentiality also extends to any assistant that may have been utilized in the preparation of the report.

An important *caveat* regarding confidentiality relates to contacts from an attorney representing the subject physician or members of the media. At no time should a case be discussed, nor should any sort of acknowledgment be given that the case has been in the past or is currently being investigated and/or reviewed. DO NOT agree to testify, on behalf of the complainant, in a civil matter regarding the review of the case. Any contact made by the media should be reported **and** referred to the Medical Board's Public Information Officer at (916) 263-2389.

The Medical Board of California Expert Reviewer Program keeps the reports written by the experts confidential to the greatest extent allowable under law.

In the event a case proceeds to an administrative hearing and rarely, to criminal proceedings, any information involved in the case, including the expert report, **may become public record** through legal discovery. Again, public disclosure of such reports is extremely uncommon.

If a case is set for hearing, the expert reviewer is expected to testify and in preparation for this testimony will meet with the DAG assigned to prosecute the case. The expert reviewer educates the attorney regarding the details of the medical opinion and assists in the presentation of that opinion in the clearest and most concise manner possible. The expert reviewer may also be asked to assist in reviewing the opinions of the opposing experts and help prepare cross examination questions regarding their opinions. The DAG will explain the procedures and protocols for testifying.

The expert reviewer is reimbursed by the Board for time spent preparing for hearing, meeting with the DAG, and reviewing additional documents. An additional Expert Statement of Services (pink billing form) will be submitted for the additional hours. **The investigator is the liaison for coordinating any reimbursements, including travel arrangements which may be required (hotel/airfare) and will be able to explain the state reimbursement rates for per diem. Please do not make flight or hotel reservations without first speaking with the assigned MBC Investigator.**

Civil Code §43.8 provides for immunity from civil liability for expert reviewers and expert witnesses acting within the scope of their duties in evaluating and testifying in cases before the Board. Should any problems arise in this area, the designated Board representative should be contacted immediately.

In the event an Expert Reviewer Program Participant, acting on the Board's behalf, is named as a defendant in a lawsuit, Business and Professions Code §2317 provides for the defense of the expert by the Office of the Attorney General.

TYPES OF EVALUATIONS

There are many possible violations of the Medical Practice Act, therefore evaluations of cases vary with the subject matter of the possible unprofessional conduct. Listed below are the types of cases the expert will review.

❑ Quality-of-Care

These cases involve the quality of medical care rendered to a patient or patients. Under the Medical Practice Act, it is unprofessional conduct for a physician to commit repeated negligent acts, gross negligence or incompetence in the practice of medicine. In quality-of-care cases, the question presented is whether the physician's diagnosis and treatment of his/her patient constitutes: (1) no departure from the standard of care; (2) negligence; (3) gross negligence; and/or (4) incompetence. When conducting your review, it is vital you understand the different definitions for each of these terms.

■ Standard of Care

The "standard of care" (also referred to as the "standard of practice") for general practitioners is defined as that level of skill, knowledge, and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent physicians in the same or similar circumstances at the time in question.

Specialists, such as anesthesiologists and ophthalmologists, are held to that higher standard of skill, knowledge and care ordinarily possessed and exercised by other reasonably careful and prudent specialists in the same or similar circumstances at the time in question.

■ Negligence

Negligence is the failure to use that level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful physicians would use in the same or similar circumstances. A negligent act is often referred to as a "simple departure" from the standard of care.

If there are multiple negligent acts, it is important to explain whether they are related acts or, alternatively, separate and distinct acts. For example, an initial negligent diagnosis (e.g., failing to correctly diagnose a broken bone) followed by an act or omission medically appropriate for that negligent diagnosis (e.g., failing to place the patient in a cast) constitutes a single negligent act. However, if a physician failed to order appropriate lab tests on three separate occasions where they should have been ordered, each of those failures is a separate and distinct negligent act because, on each visit, the physician had an opportunity to treat the patient in accordance with the standard of care. Keep in mind that there may also be situations where on the same treatment visit, there may be multiple, separate and distinct negligent acts.

- **Gross Negligence**

Gross negligence, on the other hand, is defined as "the want of even scant care" or "an extreme departure from the standard of care." Gross negligence can be established under either definition, both are not required. The difference between gross negligence and ordinary negligence is the degree of departure from the standard of care.

When determining whether a failure to practice in accordance with the standard of care constitutes either a simple or extreme departure, do not consider patient outcome or injury. Rather, focus on how, why and the degree the care provided, or not provided, to the patient deviated from the standard of care, regardless of whether ultimately there was injury or death to the patient. Some cases with significant patient injury or death may involve only simple departures from the standard of care, while other cases where the patient suffered no harm or injury at all may involve extreme departures from the standard of care.

If you conclude that a physician has committed a negligent or grossly negligent act, it is important that you identify both the specific act and the degree that it departs from the standard of care. In your expert reviewer report, each negligent act you find must be defined as either a "simple departure" or "extreme departure" from the standard of care.

Ambiguous terms, such as a "severe" or "significant" departure from the standard of care, should be avoided and, if used, will most likely require the preparation of second clarifying expert reviewer report and/or follow-up by the Medical Board investigator or HQE DAG to determine whether the act is either a "simple departure" or "extreme departure" from the standard of care.

- **Incompetence**

Incompetence is generally defined as an absence of qualification, ability or fitness to perform a prescribed duty or function. Remember that the terms negligence, gross negligence and incompetence are not synonymous. Rather, a physician may be competent or capable of performing a given duty but negligent or gross negligent in performing, for failing to perform, that duty.

★ **Terminology**

Terms to Use	Terms Not to Use
No departure	No Violation
Simple departure	Simple Negligence Ordinary Negligence Minor Violation Minor Departure Minor Deviation
Extreme departure	Gross Negligence Severe Departure Significant Departure Major Departure Major Deviation
Lack of knowledge	Incompetence Incompetent

❑ **Sexual Misconduct**

In evaluating allegations of sexual misconduct you are to assume the allegations are true. You are not being asked to evaluate or comment on the credibility of the alleged victim or whether the alleged misconduct actually occurred. A determination as to whether the alleged misconduct can be proven will be made by the Attorney General when the investigation is reviewed or by the trier of fact at the hearing.

If the issue involves a patient's account of what they feel to be an inappropriate exam, please make sure to describe in detail in your standard of care section, what the appropriate physical exam should have entailed. Then comment on what the patient described and whether or not the exam itself met the standard of care.

In reviewing cases regarding sexual misconduct, if you discover other areas of departures dealing with the medical care provided, please address those issues in your opinion as well.

Under present law regulating physicians, any act of sexual abuse, misconduct or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for discipline. This does not apply to sexual contact between a physician and his or her spouse or a person in an equivalent domestic relationship when the physician provides medical treatment, other than psychotherapeutic treatment, to that person (**Business and Professions Code §726**).

Any physician and surgeon, psychotherapist, alcohol and drug abuse counselor or any person holding himself or herself out to be one, who engages in an act of sexual intercourse, sodomy, oral copulation, or sexual contact with a patient or client, or with a former patient or client when the relationship was terminated primarily for the purpose of engaging in those acts, **unless** the physician and surgeon, psychotherapist, or alcohol and drug counselor has referred the patient or client to an independent and objective physician and surgeon, psychotherapist, or alcohol and drug abuse counselor **recommended by a third party** physician and surgeon, psychotherapist, or alcohol and drug abuse counselor for treatment, is guilty of sexual exploitation **(Business and Professions Code §729)**.

It is important in these cases to address whether or not the referral to another physician was done by an objective third party, not the subject physician.

Allegations are sometimes made that a physician has engaged in some form of sexual touching or contact with nursing staff, other physicians or some other subordinate staff person that may appear to be some form of sexual harassment. The conduct could also include verbal comments of a sexual nature or that conveys a sexual innuendo. In cases like this you are to assess whether the alleged conduct by the physician constitutes unprofessional conduct (**Business and Professions Code §2234**). Again, in making this assessment you are to assume the truth of the allegations.

❑ **Drug Violations**

Expert reviewers review a variety of drug violation cases. These drug violation cases fall into two basic categories: excessive prescribing or treatment **(as defined in Business and Professions Code §725)** and prescribing without medical indication **(Business and Professions Code §2241 and §2242)**.

- **Excessive Prescribing, under Business and Professions Code § 725**, often involves controlled substances. Generally, the assessment as to whether prescribing for a particular patient was excessive involves the nature of the medical complaint and the amount and frequency of the prescription of drugs. This can be a single drug, a class of drugs (such as opiates or amphetamines), or a pattern of prescribing large amounts of drugs without justification. An action under this section also can be sustained if the drug itself is not being given in excessive amounts, by ordinary standards, but is being knowingly given in excessive amounts for a given patient's condition. For instance, repeatedly prescribing a drug in the same amounts for a patient who has repeatedly attempted suicide using that drug constitutes excessive prescribing (among other potential violations, e.g., extreme departure from the standard of practice).

- **Prescribing controlled substances to a known addict for nonmedical purposes is illegal under Business and Professions Code §2241.** Several provisions of the Health and Safety Code prohibit prescribing controlled substances to a known addict or a representative of an

addict. In general terms, controlled substances can be provided to addicts only in certain facilities such as prisons and state hospitals, or in licensed clinics established for the treatment of drug addiction. Even in those facilities, the controlled substances must be administered directly to the patient, not prescribed or dispensed for future use. For additional information, see **Health and Safety Code §11156, §11210, §11215 and §11217.**

- **Prescribing without Medical Indication, under Business and Professions Code §2242** indicates that it is unprofessional conduct to prescribe, dispense, or furnish dangerous drugs (prescription medications, including controlled substances) "without an appropriate prior examination and medical indication." This covers the situation where a physician simply prescribes a medication, usually a controlled substance, without any underlying pathology indicating a need for that medication. This also addresses the situation where a physician, knowing that a patient is addicted to a dangerous drug, continues to prescribe that drug. Needless to say, there are many instances where prescribing without medical indication and excessive prescribing overlap. In addition, there are instances in which excessive prescribing of drugs or prescribing drugs without medical indication also constitutes an extreme departure, repeated departures, or lack of knowledge or skill, depending upon the evidence presented.

  There is an exception for the prescribing of large amounts of controlled substances for documented cases of intractable, nonmalignant pain. In these cases, expert reviewers Board certified in the area of pain management are required.

- **Intractable Pain Treatment Act under Business and Professions Code §2241.5** provides that a physician may prescribe or administer controlled substances to a person in the course of treatment for intractable pain. This refers to a patient with documented chronic, non-cancer pain, that cannot be alleviated with conventional treatment. The patient must be evaluated by the treating physician and a specialist in the area deemed to be the source of the pain. However, the physician cannot prescribe or administer controlled substances in the treatment of known addicts, treatment that is non-therapeutic in nature, or treatment that is not consistent with public health and welfare. He or she cannot violate the drug statutes governing the prescription of controlled substances and their documentation. The expert reviewer in a case in which it is claimed that controlled substances were administered for intractable pain will be called upon to determine the reasonableness of the diagnosis of intractable pain and the compliance with the accepted standard of practice for the treatment of such pain.

  When the Medical Board requests an expert opinion in a pain management case, the investigator shall provide the selected expert reviewers with the case documents to be reviewed, and provide a copy of the following:

  ⇒ Business & Professions Code Section 2190.5 (Mandatory Continuing Education Classes in Pain Management and Treatment; Exemptions)

⇒ Business & Professions Code Section 2241.5 (Intractable Pain Treatment Act)
⇒ Health & Safety Code Section 111159.2 (Treatment of Terminally Ill Patient with Schedule II Controlled Substances For Pain Relief; Prescription Requirements; Technical Errors in Certification)
⇒ Health & Safety Code Section 124961 (Pain Patient's Bill of Rights)
⇒ Guidelines for Prescribing Controlled Substances for Pain, 2003.

★ **Pain Management Guidelines**

It is imperative that when reviewing cases involving pain management, your opinion addresses the specific points of the Board's Pain Management Guidelines:

♦ **History/Physical Examination**

A medical history and physical examination must be accomplished. This includes an assessment of the pain, physical and psychological function; a substance abuse history; history of prior pain treatment; an assessment of underlying or coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of a controlled substance.

♦ **Treatment Plan, Objectives**

The treatment plan should state objectives by which the treatment plan can be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned. The physician and surgeon should tailor pharmacological therapy to the individual medical needs of each patient. Multiple treatment modalities and/or a rehabilitation program may be necessary if the pain is complex or is associated with physical and psychosocial impairment.

♦ **Informed Consent**

The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian.

♦ **Periodic Review**

The physician and surgeon should periodically review the course of pain treatment of the patient and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician and surgeon should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

- **Consultation**

  The physician and surgeon should consider referring the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Complex pain problems may require consultation with a pain management specialist.

  In addition, physicians should give special attention to those pain patients who are at risk for misusing their medications including those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse requires extra care, monitoring, documentation, and consultation with addiction medicine specialists, and may entail the use of agreements between the provider and the patient that specify the rules for medication use and consequences for misuse.

- **Records**

  The physician and surgeon should keep accurate and complete records according to items above, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan.

- **Compliance with Controlled Substances Laws and Regulations**

  To prescribe controlled substances, the physician and surgeon must be appropriately licensed in California, have a valid controlled substances registration and comply with federal and state regulations for issuing controlled substances prescriptions. Physicians and surgeons are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and the Medical Board's Guidebook to Laws Governing the Practice of Medicine by Physicians and Surgeons for specific rules governing issuance of controlled substances prescriptions.

  In rare instances you may be asked to review cases in which there has been an allegation that the physician has failed to prescribe adequate doses of pain medication to address the condition of the patient.

There are also other violations that involve drugs. Examples of these types of violations are:

- Criminal conviction for a drug violation **(Business and Professions Code §2237)**;
- Violation of Drug Statutes **(Business and Professions Code §2238)**;
- Excessive use of Drugs or Alcohol **(Business and Professions Code §2239)**;
- Intoxication While Treating Patients **(Business and Professions Code §2280).**

❑ **Excessive Treatment Violations**

Business and Professions Code §725 states it is unprofessional conduct for a physician to engage in repeated acts of clearly excessive prescribing or administering of treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities. In this type of case, you are asked to state the accepted standard of practice concerning the number of physician visits necessary to treat a certain condition, the type and extent of diagnostic procedures necessary to diagnose the condition, or the type and extent of medical laboratory tests necessary to diagnose or treat a given medical condition. Then, you are asked to determine whether the subject physician repeatedly violated these standards.

❑ **General Unprofessional Conduct**

Business and Professions Code §2234 states that a physician may be disciplined for unprofessional conduct, which is defined as such in the Medical Practice Act. Any unprofessional conduct which is not specifically set forth as such in the Medical Practice Act or other statutes covering the practice of medicine is referred to as "general unprofessional conduct." This kind of violation usually entails ethical violations such as dual relationships with patients, threatening a witness in a case, or other conduct which is prohibited by the general rules of ethics of physicians.

In a case involving ethical violations, you are asked to set forth the standard of conduct for a physician in the circumstances described, along with the underlying ethical code. You are asked to describe the manner in which the subject physician violated that standard.

Instructions for Completing your Expert Review

Thank you for providing such a valuable service to the Medical Board of California and health care consumers. As an expert reviewer, you play a vital part in protecting patients from substandard care and/or unprofessional conduct, by ensuring an objective standard of review for physicians under investigation. The following is a brief guide to walk you through the process of reviewing a case and preparing your expert report. **Please refer to the expert guidelines for a comprehensive explanation of the expert review process.**

Receiving the Case

You should have already had a conversation with a District Medical Consultant and/or an Investigator to discuss your area of specialty, and to ensure you will be a good match to perform the review.

When you receive the case binders, assess the case to determine if your training and clinical experience enable you to provide the expert review. It is very important that you have had significant experience with the procedure or medical issue during the exact time period in question. The standard of care may change over time as new methods and research are developed. Please contact the assigned investigator immediately if you have not had experience actually treating the condition or performing the procedure. The Board has many cases to be reviewed so there will be future opportunities for you to perform this valuable service.

Determine if there is any reason you cannot provide an objective opinion because of a professional, business, and/or personal relationship with the subject physician or any witness in the case. If you know the subject physician and/or any witnesses in the case, contact the assigned investigator and advise them of the nature of your relationship. You will be advised whether or not you should continue with the review.

Reviewing the Case

When you start to review the case, make sure you received everything listed on the investigator's cover letter. Audio recordings of subject interviews should be included, as well as any x-rays, ultrasounds, or other diagnostic tests. As you complete your review, if you find you are missing information vital to forming your opinion (missing medical records, illegible records, information from witnesses, medical records from another provider) contact the assigned investigator immediately and request the information needed. Please do not complete your report until the missing information is received. Preparing a report when information is missing will require you to complete an addendum report after the necessary information is obtained.

It is important that you listen to the recording of the physician interview, and not rely on the summary of the interview prepared by the investigator or medical consultant.

Do not remove any pages from or make any marks on the records provided to you. Ensure that records, reports and materials (including any audio recordings), provided for your review are kept confidential and secure. Track dates and hours spent reviewing.

Do not attempt to contact any witnesses yourself. Keep all materials confidential and do not discuss the case with anyone other than Board staff. If you find potential problems with the care other medical providers have given, call the assigned investigator and let them know your concerns. Do not include that information in your report. Another case can be opened on the provider you have identified.

You are authorized 10 hours at the beginning of your review, however, if you need more time, contact the assigned investigator. The important thing is to obtain authorization for more hours before you complete them. Additional hours need to be approved in advance in order to avoid a delay in reimbursement.

Preparing your Report

Your expert report is the most important aspect of your review. Your report will be reviewed by the Investigator and Deputy Attorney General assigned to the case to determine how the case will proceed. Oftentimes experts are asked to provide addendum reports to clarify statements made or to comment on issues that were not addressed. The following expert report format was designed to limit the need for expert addenda and provide an easy template for you to follow in preparing your report.

Your expert report should be typed and submitted on your office letterhead. The pages should be numbered and it should be signed and dated on the last page. Review your report against the samples provided. Make sure you followed the correct format and included all the headings and sections required.

It is important to note that there is no such thing as a draft report. Do not send or fax drafts to the assigned investigator. Do not email your report. Email and faxed reports are not acceptable. If you have any questions about the preparation of your report, please call the assigned investigator.

Below is an Expert Reviewer Checklist. This will assist you to confirm that all the necessary requirements of the expert report have been met. The Board is doing everything possible to prevent the need for an addendum. Expert addenda often detract from an expert's credibility. If the proper expert review is completed, there will be no need for an addendum. The only exception would be if the Board sent you materials at a later time to review and wanted you to prepare a brief addendum stating whether or not the additional materials change your original opinion. An example of this would be expert depositions that are not sent to you originally so that your opinion is not biased.

Please complete the Expert Reviewer Checklist for each case you review and submit the completed checklist with your statement of services.

Expert Reviewer Checklist

☐ I have reviewed all materials provided to me, including the audio tape or CD of the physician interview.

☐ I have followed the format for the expert report by identifying a list of medical issues, and for each issue, I have included a standard of care, analysis, and conclusion section.

☐ In my conclusion section, I have only used the correct terms of **no departure, simple departure, extreme departure, and/or lack of knowledge** .

☐ I have submitted my expert report on my letterhead; it is dated, paginated, and includes my signature.

☐ I have included a current copy of my curriculum vitae.

☐ I have included my completed Expert Statement of Services Form (ER-8 pink) and have attached the necessary receipts for items such as transcription costs.

_____ _____

Expert Reviewer Signature Date

When you have completed your report and checklist, please contact the assigned investigator to arrange for the return of your report and case materials. Make sure you have also completed an Expert Statement of Services Form (pink billing form) and submit it with your expert report, completed checklist, and your current curriculum vitae. Double check to make sure you have included receipts for any expenses, i.e. transcription costs. Keep a copy of your statement of services and receipts for your records.

THE OPINION ITSELF

There are Model Expert Opinions appended to these guidelines. Please refer to those when writing your opinion, but remember they are only examples.

❑ **Contents - your expert opinion should contain the following headings:**

- **Materials Reviewed**
  - ▸ List all attachments and property items given to you for review.
  - ▸ Listen to the audio recordings (of interview) provided to you before reaching an opinion or finalizing your report.
- **Summary of Case**
  - ▸ Do not rely on the medical consultant's summary, you must create your own summary from the materials provided to you.
  - ▸ Describe the treatment history of the patient with the subject practitioner. When did he/she start seeing the doctor, what for, what symptoms were being treated, and how.
  - ▸ When referring in your report to a specific document/medical record in the materials provided to you, identify it in parenthesis; i.e. "Chest x-rays disclosed a 7mm coin lesion of the right lung (Attachment 4, page 9)."
- **Medical Issues Identified**
  - ▸ Address all medical issues identified by the Central Complaint Unit (CCU) Medical Consultant and/or the District Office Medical Consultant (DMC). Also discuss any other medical issues that you have identified.
  - ▸ Number the medical issues. The medical issues will be broken down and discussed further in your opinion.
- **Standard of Care**
  - ▸ For each medical issue identified you will have a sub-heading of "Standard of Care." Provide a detailed description of the standard of care for each medical issue. Be careful not to substitute your own practices (which may be above and beyond the standard) for the standard of care.

- The standard of care is the level of skill, knowledge, and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent physicians in the same or similar circumstances at the time in question.

- It is also important to note that you are examining the practitioner's acts based on the standards in place at the time of the acts or treatment, not by today's standards. The standard of care can change in specialty practice and you have to articulate what the standard was at the time of the alleged conduct.

- **Analysis**

  - For each medical issue identified you will have a sub-heading of "Analysis." This will directly follow the standard of care section for the medical issue.

  - Here you will apply the facts of the case to the standard of practice. You will describe what the subject physician did or did not do relating to the standard of care. Refer to page numbers of the medical records in parenthesis as you go. This is helpful not only to those reading your opinion, but also if you are needed to testify at an administrative hearing. Having page numbers identified makes it easy for you to refresh your recollection of the case and to be able to explain your conclusions.

- **Conclusion**

  - For each medical issue identified you will have a sub-heading of "Conclusion." This will directly follow the analysis section.

  - Describe the departures from the standard of care. You must only use the following terminologies: no departure, simple departure, extreme departure, and/or lack of knowledge

  - The "standard of care" (also referred to as the "standard of practice") for general practitioners is defined as that level of skill, knowledge, and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent physicians in the same or similar circumstances at the time in question.

    Specialists, such as anesthesiologists and ophthalmologists, are held to that higher standard of skill, knowledge and care ordinarily possessed and exercised by other reasonably careful and prudent specialists in the same or similar circumstances at the time in question.

Negligence is the failure to use that level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful physicians would use in the same or similar circumstances. A negligent act is often referred to as a "simple departure" from the standard of care.

If there are multiple negligent acts, it is important to explain whether they are related acts or, alternatively, separate and distinct acts. For example, an initial negligent diagnosis (e.g., failing to correctly diagnose a broken bone) followed by an act or omission medically appropriate for that negligent diagnosis (e.g., failing to place the patient in a cast) constitutes a single negligent act. However, if a physician failed to order appropriate lab tests on three separate occasions when they should have been ordered, each of those failures is a separate and distinct negligent act because, on each visit, the physician had an opportunity to treat the patient in accordance with the standard of care. Keep in mind that there may also be situations where on the same treatment visit, there may be multiple, separate and distinct negligent acts.

Gross negligence, on the other hand, is defined as "the want of even scant care" or "an extreme departure from the standard of care." Gross negligence can be established under either definition, both are not required. The difference between gross negligence and ordinary negligence is the degree of departure from the standard of care.

When determining whether a failure to practice in accordance with the standard of care constitutes either a simple or extreme departure, do not consider patient outcome. Rather, focus on how, why and the degree the care provided, or not provided, to the patient deviated from the standard of care, regardless of whether ultimately there was injury or death to the patient. Some cases with significant patient injury or death may involve only simple departures from the standard of care, while other cases where the patient suffered no harm or injury at all may involve extreme departures from the standard of care.

- Be sure to explain why the care provided, or not provided, to the patient is a departure from the standard of care. For example, do not just state your conclusion that the physician's care was a simple or extreme departure from the standard of care. State why and be specific. Your conclusion might be the doctor failed to order follow up laboratory tests and that is a _____ departure from the standard of care.

- Ambiguous terms, such as a "severe" or "significant" departure from the standard of care, should be avoided and, if used, will most likely require the preparation of second clarifying expert reviewer report and/or follow-up by the Medical Board investigator or HQE DAG to determine whether the act is either a "simple departure" or "extreme departure" from the standard of care.

- Each medical issue might have multiple areas to be discussed. Be sure to state your conclusions for each.

- Incompetence is generally defined as an absence of qualification, ability or fitness to perform a prescribed duty or function. Remember that the terms negligence, gross negligence and incompetence are not synonymous. Rather, a physician may be competent or capable of performing a given duty but negligent or gross negligent in performing that duty.

Terms to Use	Terms Not to Use
No departure	No Violation
Simple departure	Simple Negligence Ordinary Negligence Minor Violation Minor Departure Minor Deviation
Extreme departure	Gross Negligence Severe Departure Significant Departure Major Departure Major Deviation
Lack of knowledge	Incompetence Incompetent

❑ Multiple Patients

When reviewing a case involving more than one patient, summarize, discuss, establish the standard of care, and reach your conclusions for each patient independently. If you receive multiple cases on the same subject physician but they have different case numbers, prepare a separate report for each case number, do not combine them in one report.

❑ Objectivity

It is critical to the integrity of due process that you conduct your review and prepare your report with objectivity. Remember that you are neither an advocate for the Board nor the physician. Do not make judgments or subjective comments. View the assigned case without regard to any other legal activity which may surround it. Specifically, you should ignore the existence, nonexistence or magnitude of any civil judgments or settlements involving the case. Since you may not be reviewing the same documents which were used to support or refute a civil case, you should not consider any past adjudicatory history. The expert reviewer should focus on the

medical and other case records, not on the reports, depositions or testimony of other expert witnesses.

❑ Affect of Mitigation

In writing your opinion, you are asked to summarize the treatment rendered and the findings of the subject physician. There may have been factors in the case that prevented treatment consistent with the accepted standard of practice. If so, identify those factors. Please remember that it is your obligation to state the standard of practice and any departure from it.

Mitigation is defined as an abatement or diminution of penalty or punishment imposed by law. Although there are instances where mitigating circumstances are relevant to the imposition of any penalty, those factors will be considered by the trier of fact (the ALJ). Therefore, you are asked to refrain from commenting whether the subject physician should or should not be punished because of certain mitigating or aggravating factors. Clearly state in your opinion what the mitigating or aggravating factors involved in the case are. Do not state an opinion as to the degree the circumstances should affect the discipline imposed. The actual discipline to be imposed on the physician is the province of the trier of fact, and you are not expected to prescribe or recommend any discipline in the case.

❑ Injury Is Not Essential

The focus of an expert review is on whether there has been a departure from the accepted standard of practice, not whether the patient has been injured. Although the potential for injury exists due to the departure from the standard of practice, and the degree of that departure, actual injury is not required to establish a violation of the Medical Practice Act. Patient outcome is not to be considered when determining whether the departure is simple or extreme.

❑ Physician Responsibility

During the course of a review, you may have to determine the level of responsibility of a supervising physician. The attending physician is ultimately responsible for the care provided to the patient. Therefore, if resident physicians are providing care to the attending physician's patient, part of the attending physician's responsibility is to provide appropriate supervision of the residents. Attending physicians are expected to use good judgment in determining the level of supervision appropriate for the situation.

These physicians must take into account the clinical problems being addressed and the resident's level of training, skill and knowledge. Reviewers, in assessing whether good judgment was used, should consider what a reasonable and prudent physician would do in the circumstances under review. Obviously, even a well-supervised resident can deliver substandard care, particularly if there is malevolent intent. The attending physician, however, cannot be blamed for an adverse event if he or she took reasonable steps to provide appropriate supervision and oversight.

Among the most useful evidence indicating that appropriate actions were taken is documentation in the medical record.

❑ **No Legal Conclusions**

You are not asked to determine whether the subject physician's conduct is a violation of a certain statute. You are asked to render an opinion as to whether the subject physician's conduct violated the standard of practice and to what degree and in what manner. Therefore, refrain from characterizing the acts of the subject physician as "gross negligence," "repeated acts of negligence," and so on. Instead, characterize your opinion in terms of identifying any departures from the established standard of practice and the degree of that departure. For examples of this, please refer to the model expert opinions in this manual.

❑ **Assess the Standard of Practice As of the Time of the Violation**

The standard of practice is constantly evolving, and so it is particularly important to be cognizant of the time that the violation occurred and assess the case in terms of the standard of practice **AT THAT TIME**. For instance, the prescribing of a certain drug for a medical condition may be totally contraindicated now, but if the subject physician prescribed it in 2004, the state of knowledge about that drug and its contraindications may not have been as clear. Thus, any opinion should speak to the standard in 2004, not the standard at the present time.

❑ **Terms to Avoid**

Exacerbation: Certain situations or conditions may exacerbate a physician's actions with respect to a case. For example, being inebriated while seeing a patient may exacerbate an underlying lack of knowledge or ability. While it is appropriate to describe exacerbating conditions, an expert reviewer should not assign value judgments to them. This will be done at hearing.

Guilt or Innocence: The expert reviewer's role is to determine whether, and in what manner, a physician's actions depart from the standard of medical practice, or demonstrate a lack of knowledge or ability. The trier of fact will determine guilt or innocence.

Judgmental or subjective comments: Avoid terms such as "this guy is clearly incompetent" or "no one in his right mind would do . . . " Your report should objectively establish what behavior was expected and how the physician failed to meet the expectation.

Malpractice: Malpractice is a term which applies to civil law (i.e., suits between individuals). The Medical Board functions under administrative law, and its cases are based on violations of that law involving unprofessional conduct. Expert reviewers should not let information regarding malpractice filings, settlements or judgments affect their review of a case. The standards of evidence and proof for civil cases differ from administrative cases.

Penalties: It is not the role of the expert reviewer to propose or recommend a penalty. This will be determined at hearing, based on detailed guidelines adopted by the Board and utilized by Administrative Law Judges.

Personalized comments: Avoid characterizing the actions of the physician in personal terms: "she was rude and unprofessional to the patient." Instead, describe what the expected standard was, and how the physician deviated from the standard: "The standard of practice is to explain the procedure, answer the patient's questions, and obtain informed consent. There is no record showing that the procedure was explained to the patient and informed consent obtained."

MODEL EXPERT OPINION #1

This opinion is an example of a written report prepared according to guidelines/recommended report format. It is provided for the purpose of reference as to form and expressions only, and in no way, reflects the decisions of the Board. The places, persons, and events are fictional.

Robin Jones, M.D., F.A.C.S.
General Surgery
Diplomate, American Board of Surgery
800 E. Walnut St., Suite 100
Los Angeles, CA 90013
Tel. (213)551-0000; Fax (213) 551-0001

Date

Investigator/Medical Consultant (requesting review)
Medical Board of California
Street Address (of District Office requesting review)
City CA Zip

Re: Jane Doe, M.D.
Case: 17-2008-000000
Patient: Joe Smith

MATERIALS REVIEWED:

1. Investigation report
2. Memorandum from District Medical Consultant
3. 801 Report
4. Curriculum vitae of Dr. Jane Doe
5. Operative/Pathology report
6. Certified medical records from Dr. Jane Doe
7. Certified medical records from Dr. Jon Deere
8. Certified medical records from Eastside Community Hospital
9. Medical photographs
10. CD of interview of Dr. Jane Doe
11. CD of interview of Dr. Jon Deere

SUMMARY OF CASE:

This case was initiated by the Medical Board of California upon receipt of a Business and Professions Code, Section 801 report. Eighty thousand dollars was awarded to Joe Smith (patient) by XYZ Indemnity Company on behalf of their insured, Dr. Jane Doe. According to the report, the right side of the colon was removed on 7/26/04 for treatment of what appeared to be a colon cancer.

Review of the medical records of Dr. Doe showed that Dr. Deere had performed a colonoscopy for persistent abdominal pain on 7/25/04 (page 2). Dr. Deere obtained photographs of biopsy specimens of what he interpreted to be a right colon mass. Both Dr. Deere (gastroenterologist) and Dr. Doe (surgeon) agree that Dr. Deere contacted Dr. Doe the same day of the colonoscopy and asked him to operate on the patient (page 3 of Dr. Deere's records, page 1 of Dr. Doe's records). The patient was admitted to Eastside Community Hospital that afternoon (page 1 of hospital records). Dr. Deere gave the patient a bottle with a biopsy specimen to be hand carried to the hospital (Dr. Deere's records, page 3). Dr. Doe claimed that Dr. Deere (referring physician) had instructed her to operate on patient John Smith without awaiting for biopsy results because the colonoscopy findings were consistent with cancer. The surgeon, Dr. Doe claimed that Dr. Deere had told her that this was a very fragile patient, who just had undergone an extensive bowel preparation and he wanted to avoid the patient the trauma of a second bowel preparation (page 3 of Dr. Doe's records). Dr. Deere stated that as shown by the colored photographs, colonoscopy findings were "consistent with colon cancer."

Preoperative work up showed that there were electrocardiographic abnormalities consisting of T-wave inversions and some ST depressions (page 7 of hospital records). Chest x-ray disclosed a 7 mm coin lesion of the right lung (page 9 of hospital records).

A partial colectomy was performed by Dr. Doe on the day following colonoscopy (page 12 of hospital records). All involved parties agreed that at that time, no biopsy results of colonoscopy specimens were available. At operation, a mass like structure was palpated by the surgeon in the ascending colon (page 25 of hospital records). There was no documentation of a thorough evaluation of the remainder of the large bowel nor of a complete abdominal exploration. Dr. Doe performed removal of the right side of the colon (page 16 of hospital records). She re-established the continuity of the bowel transit by bringing together the terminal small bowel with the remaining colon. Upon removal of the operative specimen, she opened it and realized that what appeared to be tumor was actually a conglomerate of hard feces (page 16 of hospital records). She told the patient and the patient's family of her error. She watched the patient postoperatively. Hospital records showed that on 7/30/04 and 7/31/04, serum potassium was 2.5 and 2.6, respectively (pages 31 & 32 of hospital records). There was no documentation in records showing that the patient received aggressive treatment of this low serum potassium. The patient was discharged on 8/4/04.

MEDICAL ISSUES:

1. Initial evaluation of the patient by the surgeon

- **Standard of Care:**

  Elective colon resection for colon cancer requires a positive diagnosis. This is achieved by awaiting the written pathologist's report of the biopsies taken at colonoscopy, or at least the pathologist's verbal report.

- **Analysis:**

  Dr. Doe operated on this patient based on the verbal report of the colonoscopist and her own assessment of the photographs obtained at colonoscopy. She alleged that she wanted to avoid another bowel preparation to the patient. This is not a valid reason. The risk of performing an unnecessary colon resection by far outweighs the risks of another bowel preparation and waiting for a definitive pathology result.

- **Conclusion:**

  Extreme departure from the standard of care for performing colon resection without a pathology report corroborating the suspected diagnosis of cancer.

2. Medical clearance for operation

- **Standard of Care:**

  The standard of care is to evaluate the suitability for operation prior to performing general anesthesia and colon resection. This is best done by an internist, a cardiologist or a pulmonologist. Preoperative clearance for operation by the surgeon is acceptable if the surgeon has comparable knowledge, orders and interprets all required preoperative tests and properly acts upon evaluating the test results.

- **Analysis:**

  This patient had co-morbid conditions. There was no documented discussion about the abnormal electrocardiographic results which showed myocardial ischemia. No reason was documented of why the possibility of myocardial ischemia was not further evaluated prior to subjecting this patient to elective surgery. The presence of a lung coin lesion may or may

not be related to spread of an alleged cancer. Its mere presence is not a contraindication for operation because even if this would be a small metastasis of the cancer, an unchecked colon lesion exposes a patient to early death due to bleeding, obstruction or perforation.

During the subject interview, Dr. Doe stated she referred the patient to cardiologist, Dr. Buck. However, Dr. Doe admitted that she did not document her evaluation of the patient, nor the referral to the cardiologist.

- **Conclusion**:

Simple departure from the standard of care for failure to document an evaluation for possible myocardial ischemia prior to elective operation.

3. Intraoperative evaluation of the mass

- **Standard of Care**:

The standard of care is to perform a thorough intraoperative evaluation of the suspected mass. This should include a thorough palpation to ensure that the mass is actually attached to the bowel wall and not merely bowel contents. It should comprise an evaluation of the adjacent bowel wall to detect the degree of penetration of the lesion into the wall. A comparison of the operative findings with the colonoscopic findings should be performed. Bowel palpation can determine whether the mass has the softness of stool or the hardness of a malignant tumor. The remainder of the colon should be evaluated to determine whether there is a single lesion or multiple ones. Thorough exploration should be performed to determine extension of tumor into the lymph nodes or other abdominal organs. The presence of peritoneal seeding by cancer should be checked by running the small bowel from the ligament of Treitz to the ileocecal valve. The surgeon should confirm the actual presence of a mass and to dispel any doubts regarding its presence, prior to proceeding with resection.

- **Analysis**:

In this particular case, the surgeon alleged to have performed "palpation of the small and large bowel" intraoperatively but she did not document a thorough examination of the colon nor small bowel. She did not document evaluating the "mass" to rule out any entity simulating a tumor such as hard bowel contents. There was no mention in her report of any attempt to evaluate for bowel wall involvement, mobility of the suspected mass and staging of tumor. The surgeon's reliance on the colonoscopic findings was not justified. The colonoscopist had told her that the bowel was well prepared. The whole objective of

proceeding promptly with operation was to take advantage of such alleged bowel emptiness. At operation, the surgeon corroborated that the bowel was not empty. Further reliance on the colonoscopist's contentions could not be justified.

- **Conclusion**:

Extreme departure from the standard of care for inadequate intraoperative evaluation and staging of suspected colon cancer.

4. Medical records keeping

- **Standard of Care**:

The standard of care is to proceed with operation after a history and physical had been documented in records.

- **Analysis**:

The history and physical of this patient was dictated five weeks after admission. It was performed after a surgical error and its consequences were known.

- **Conclusion**:

Simple departure from the standard of care for proceeding with operation without a history and physical examination in records.

5. Coverage of the postoperative internal medicine needs of the patient

- **Standard of Care**:

The standard of care is that the internal medicine needs of an operated patient be properly taken care for. This is usually done by an internist or hospitalist. It could also be properly performed by a knowledgeable surgeon.

The standard of care is to keep the potassium level within normal limits (3.6-5.5 MEQ/L).

- **Analysis**:

  In this particular case, laboratory tests showed persistently low potassium. No internist was consulted. The surgeon chose not to add a potassium "rider" but to slowly replenish the potassium level over several days.

- **Conclusion**:

  Simple departure from the standard of care for failure to increase potassium level in a more rapid manner.

(Signature) Robin Jones, M.D. (Date) 1/5/09
ROBIN JONES, M.D., F.A.C.S.

References:

MODEL EXPERT OPINION #2

This opinion is an example of a written report prepared according to guidelines/recommended report format. It is provided for the purpose of reference as to form and expressions only, and in no way, reflects the decisions of the Board. The places, persons, and events are fictional.

Anthony Brown, M.D., A Professional Corp.
Diplomate, American Board of Psychiatry
123 Central Avenue, Suite 500
Sacramento, CA 95825
(916) 263-0000

Date

Investigator/Medical Consultant (requesting review)
Medical Board of California
Street Address (of District Office requesting review)
City CA Zip

Re: Jane Doe, M.D.
Case: 17-2008-000000
Patient: Joe Smith

MATERIALS REVIEWED:

1. Investigation report
2. Partially Redacted Memorandum from CCU Medical Consultant
3. Patient Complaint
4. Certified medical records from Dr. Jane Doe
5. Certified medical records from Dr. Jon Deere
6. Certified medical records from Eastside Community Hospital
7. Recorded pretense call between Joe Smith and Jane Doe, M.D.
8. Curriculum vitae of Dr. Jane Doe
9. Memorandum from District Medical Consultant Jones
10. CD of interview of Dr. Jane Doe

SUMMARY OF CASE:

This case was initiated by the Medical Board of California upon receipt of a patient complaint received from Joe Smith. Joe Smith is a 21 year old student attending the University of California, Oxnard. He first received psychiatric treatment on March 15, 2007. At the time, Mr. Smith had sought evaluation at the Eastside Community Hospital for a 1-2 month history of auditory

hallucinations critical of him and telling him to kill himself. The patient was placed on a "5150" involuntary hold as a danger to himself, and was admitted on an involuntary basis to Eastside Community Hospital for inpatient psychiatric treatment. [7] He was an inpatient for three days under the care and treatment of the attending psychiatrist Dr. Jane Doe, until his discharge from the hospital on March 18, 2007. The patient's admission and discharge diagnosis from Eastside Community Hospital was "Psychotic Disorder, Not Otherwise Specified." [12] He had been treated with the anti-psychotic medication Zyprexa, and was discharged with instructions to continue Zyprexa at 10mg a day, and pursue psychiatric treatment. [14]

Mr. Smith continued in psychiatric treatment with Dr. Jane Doe as an outpatient after his discharge from the hospital. He attended a total of seven outpatient sessions with Dr. Doe, from April 2007 until August 2007. During their last session on August 18, 2007, Dr. Doe noted that Mr. Smith was "still complaining of depression and sleep problems."[31] She noted that his primary care MD, Dr. Deere, had changed the antidepressant medicine from Prozac to Effexor and had prescribed the anti-anxiety and sleep medicine Ativan, as well as Ambien. [31] She further noted that the patient "needs an antipsychotic medicine", and changed his diagnosis from "Psychotic Disorder, NOS" to "Major Depression with Psychotic Symptoms in partial remission."[32] She wrote that Mr. Smith was to return to her office in one month. At the last session, Dr. Doe did not terminate the treatment, rather Mr. Smith chose not to return for his next scheduled session.

Mr. Smith reports that his next contact with Dr. Doe was about two months later, in October 2007. He states that they ran into each other at a shopping mall, and briefly greeted each other. The next contact was in early December 2007, when they ran into each other at a book store, The Read 'til U Drop. Mr. Smith states that Dr. Doe approached him while he was in the parking lot of the bookstore and gave him her card. A week later, Mr. Smith called and left a message for Dr. Doe, inviting her to attend a concert in Santa Barbara. He states that Dr. Doe met him at the concert, and they had their first sexual encounter later that night. He states that they did not see each other over the holidays. However, from January to March, 2008, they saw each other at least 3-4 times a week, during which time they had sexual relations on a number of occasions.

During this time, Mr. Smith was being treated by Dr. Deere for various issues. On a February 2, 2008 visit, Dr. Deere noted, "I am suspicious that the symptoms the patient complains of with left sided pain is probably related to musculoskeletal tension that might be related to underlying unclear etiology as well as to his depressed mood and the general life stressors that have impinged on him recently. . . I have referred this patient to follow-up with a psychiatrist . . . and I believe that he will benefit from a course of antidepressant medication. . ." [24] On another visit on February 9, 2008, Dr. Deere notes : "I strongly feel that this patient is increasingly depressed, will reevaluate medication." [28]

Dr. Deere informed Sr. Inv. Coe that while Mr. Smith did not provide specific details, he did advise Dr. Deere that he had began a new relationship during this time. This information is noted in Dr. Deere's visit note of January 27, 2008 [15] Mr. Smith states that his disabling symptoms seemed to increase during the time he and Dr. Doe were seeing each other.

On June 15, 2008, Mr. Smith made a pretense call to Dr. Doe. During the conversation Mr. Smith told Dr. Doe that he missed her and wanted to see her again. Dr. Doe does not respond to Mr. Smith's requests, except to state that she is unable to talk to him, and will call him at a later time.

In her recorded interview with the Medical Board, Dr. Doe denies that she had sexual relations with Mr. Smith. Although, she admits that she attended a concert at Mr. Smith's request.

MEDICAL ISSUE(S):

1. Sexual Relations with a Patient or Former Patient

- **Standard of Care:**

  The 2001 Code of Ethics of the American Medical Association and the American Psychiatric Association established the standard of care regarding physicians having a sexual relationship with a patient or former patient.

  The American Psychiatric Association Principles of Medical Ethics (2001:section 2.1) concludes the following:

  "The requirement that the physician conduct himself/herself with propriety in his/her profession and in all actions of his/her life is especially important in the case of the psychiatrist because the patient tends to model his/her behavior after that of his/her psychiatrist by identification. Further, the necessary intensity of the treatment relationship may tend to activate sexual and other needs and fantasies on the part of both the patient and psychiatrist while weakening the objectivity necessary for control. Additionally, the inherent inequality in the doctor-patient relationship may lead to exploitation of the patient. Sexual activity with a current or former patient is unethical."

  The American Medical Association Code of Ethics, section 8.14 state:

  "Sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic

relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions or influence derived from the previous professional relationship."

The standard of care is for a psychiatrist NOT to have a sexual relationship with a patient or former patient.

- **Analysis:**

Dr. Doe had an established doctor-patient relationship with Mr. Smith. Several months after his last visit with Dr. Doe, Mr. Smith and she entered into a sexual relationship. Although, neither Dr. Doe nor Mr. Smith terminated the doctor-patient relationship, he was being treated by another psychiatrist at the time they began their sexual liaison, therefore while arguably he may have been considered a patient he was definitely a former patient. In any event, Dr. Doe departed from the standard of care by engaging in a sexual relationship with Mr. Smith.

- **Conclusion**:

Extreme departure from the standard of care for engaging in a sexual relationship with a former patient.

(Signature) Anthony Brown, M.D. (Date) 1/5/09
ANTHONY BROWN, M.D.

References:

1. American Medical Association Code of Ethics, 2001

2. American Psychiatric Association Principles of Medical Ethics, 2001

3. xxx

MODEL EXPERT OPINION #3

This opinion is an example of a written report prepared according to guidelines/recommended report format. It is provided for the purpose of reference as to form and expressions only, and in no way, reflects the decisions of the Board. The places, persons, and events are fictional.

Note: In sexual misconduct cases, there are usually two versions of the events. The patient will allege that sexual misconduct occurred. The physician may allege that sexual misconduct did not occur or that the physician's actions were misinterpreted by the patient. The role of the expert reviewer is not to determine who is right or who is wrong. ***The role of the expert is only to determine whether or not the actions alleged by the patient constitute a departure from the standard of care****. It is the role of the trier of facts to determine the validity of the allegations. PLEASE DO NOT ADD ANY COMMENTS IN YOUR OPINION ABOUT WHAT YOU BELIEVE COULD HAVE HAPPENED.* ***Any unsolicited comments may compromise the integrity of the case****.*

Douglas Jones, M.D., Inc.
1320 The City Drive, Suite 800
Orange, CA 92868
Tel. (714)123-4567

Date

Investigator or Medical Consultant (requesting review)
Medical Board of California
Street Address (of District Office requesting review)
City CA Zip

Re: Case 17-2008-000000 (John Doe, M.D.)

Materials Reviewed:

1. Investigation report
2. Complaint from SF Police Department
3. Complaint from Patient Jane Go
4. Complaint from Patient Susan Dove
5. Medical records of Patient Go from Dr. Doe
6. Medial records of Patient Dove from Dr. Doe
7. SF Police Department's report on patient Dianna Smith
8. Medical Records of Dianna Smith from Dr. Doe

PATIENT: DIANNA SMITH

♦ **Summary of Case:**

On 2/1/08, Dianna Smith reported to the San Francisco Police Department what she thought was unusual behavior of Dr. John Doe during her last visit at his office. Patient Smith stated that she was seen by Dr. Doe on 2/1/08 for her annual physical examination. While she was in the examining room, behind closed doors, Dr. Doe started to touch her in an unusual manner. Patient Smith first thought it was part of the examination and allowed him to continue. Then, Dr. Doe touched and rubbed her breasts with his hands. He then placed his hand next to her vaginal area, maneuvering his hands under the garments and touching her vagina. At that time patient Smith pushed him away and told him that she was going to report his actions.

Dr. Doe opened the door and allowed patient Smith to leave. She went home and told her mother and was advised to file a report.

♦ **Medical Issue(s) Identified:**

1. Examination of breasts and genitalia

■ **Standard of Care:**

The standard of care is to perform breast and genital examination in the presence of a female chaperone. The standard of care for breast examination is to advise the patient that her breasts are going to be examined and to obtain her permission for breast examination. The standard of care does not include rubbing the breast or touching them for no medical reason. The standard of care is to touch the genitalia of a female patient only for good medical reason and after obtaining permission from the patient to proceed with such examination. The standard of care is to touch the genitalia of the patient only while wearing gloves.

■ **Analysis:**

Dr. Doe did not allege that a chaperone was present during the patient's examination. He did not allege that he obtained consent for breast and genital examination of the patient. There was no documentation showing that the patient was in gynecological position nor that Dr. Doe was gloved while performing genital examination.

- **Conclusion:**

  The alleged actions of Dr. Doe represent an extreme departure from the standard of care because he did not have a chaperone present while examining the breasts and genitalia of a patient. He did not obtain her consent for such examinations and the patient was not properly positioned for pelvic examination. He did not wear gloves during examination.

PATIENT : JANE GO

♦ **Summary of Case:**

Patient Jane Go was a 32-year-old divorcée who saw Dr. Doe for a variety of medical problems from 2002 to July 2008. In January 2007, she began to have a social relationship with Dr. Doe which led to a sexual relationship. She continued to have sexual relations with Dr. Doe until July 2008 when she found out that Dr. Doe was unfaithful to her and was having sexual relations with other patients. She decided to report him to the Medical Board of California.

♦ **Medical Issue(s) Identified:**

1. Sexual relations with patient

- **Standard of Care:**

  The standard of care is to preserve the boundaries of the physician-patient relationship.

- **Analysis:**

  There is documentation showing the existence of a patient-physician relationship which was uninterrupted from 2002 until July 2008. There is an allegation of repeated sexual relations while patient Go was being cared for by Dr. Doe.

- **Conclusion:**

  Dr. Doe's alleged action is an extreme departure from the standard of care (sexual relationship with an active patient).

PATIENT: SUSAN DOVE

♦ **Summary of Case:**

Patient Susan Dove was a 34-year-old female undercover agent who was equipped with a hidden surveillance equipment. She consulted with Dr. Doe on 7/1/08 for an ankle injury. At interview, she told Dr. Doe that she was a professional tennis player who had injured her ankle. Dr. Doe examined her and prescribed two medications for pain and inflammation. He then walked over to the sink and washed his hands. While the patient was sitting on the examination table, he stood in front of her with a light instrument and checked her eyes and mouth. He then asked her to turn her head to the right to check her left ear. At that time he quickly lifted up her shirt from the waist above her left breast. He lifted up her left breast and pulled up the left side of her bra. Her breast was exposed and he touched her nipple and breast with his hands. Patient Susan Dove pushed him away and asked in shock, "whoa, whoa, whoa, what are you doing?" She quickly pulled down her bra and shirt. Dr. Doe stepped backward and stated that he was sorry and that he was trying to check her stomach.

♦ **Medical Issue(s) Identified:**

1. Appropriateness of stomach examination/touching breast and nipple during stomach examination

■ **Standard of Care:**

The standard of care is to avoid exposure of the breast while a chaperone is not present in the room. The standard of care is to avoid touching the breast and nipple while performing abdominal examination. The standard of care is to perform abdominal examination with the patient lying down. If large breasts impede adequate abdominal examination, asking the patient to raise her arms, will raise the breasts sufficiently.

■ **Analysis:**

Review of video images corroborated that the breasts were exposed while in sitting position. It showed that one hand of the physician (Dr. Doe) was placed upon the breast and nipple. There was no documentation showing that there was a chaperone in the room. There was no documentation showing that the patient was advised that her breasts were going to be touched nor was there any documentation showing that permission was granted for lifting the breasts. Palpation of the abdomen was not performed after lifting the breast. If it was performed, it would have been below the standard examination

practice because the patient was in sitting position. The patient was not requested to raise her arms to lift her breasts. There was no medical reason to uncover the breasts.

- **Conclusion:**

Dr. Doe's alleged action is an extreme departure from the standard of care because he uncovered the patient's breast without a chaperone in the room. He touched the breast and nipple without good medical reason. He alleged that he attempted to perform examination of the abdomen, in substandard fashion.

(Signature) Douglas Jones, M.D. (Date) 1/5/09
DOUGLAS JONES, M.D.
Diplomate, American Board of Internal Medicine

MODEL EXPERT OPINION #4

This opinion is an example of a written report prepared according to guidelines/recommended report format. It is provided for the purpose of reference as to form and expressions only, and in no way, reflects the decisions of the Board. The places, persons, and events are fictional.

Ray Roenten, M.D.
Diplomate, American Board of Radiology

800 E. Walnut St., Suite 100
Glendale, CA 91206
Tel. (818) 551-0000; Fax (818) 551-0001

Date

Investigator/Medical Consultant (requesting review)
Medical Board of California
Street Address (of District Office requesting review)
City, CA Zip

Re: John Doe, M.D.
Case: 17-2008-000000
Patient: Jane X. Smith

MATERIALS REVIEWED

1. Senior Investigator's report.
2. Memorandum from District Medical Consultant.
3. Consumer complaint from patient Jane X. Smith.
4. Dr. John Doe's summary of care involving patient Jane X. Smith.
5. Certified copy of patient Jane Smith's record from North South Diagnostic Medical Group (NSDMG) from January 2003 through July 2007.
6. Certified copy of two missing pages (June 25, 2006 & August 19.2006) of patient Jane X. Smith's medical records from NSDMG.
7. Certified copy of patient Jane X. Smith's medical records from EMT Services.
8. A CD digital recording of Dr. John Doe's interview conducted on 5-28-08.

SUMMARY OF CASE:

Patient Jane X. Smith was a 37 year-old female who underwent an MRI study of her left shoulder at NSDMG under the direction of subject physician Doe on 1-17-07.

Patient Smith had previously undergone an MRI study at the same facility on 8-28-06 and at that

time had completed a pre-scan patient evaluation indicating that she was subject to panic episodes and had some level of claustrophobia and anxiety. Based on the clinical history, she was pre-medicated with 7.5 mg. of po Valium, prescribed by an attending radiologist for purposes of light sedation for the MRI study of 8-28-06. That study performed on 4-13-06 of the lumbar spine was completed with the patient's anxiety level measured as a 2/10 during the study.

The patient returned to the same facility on 1-17-07 for an MRI of the shoulder and she again completed a pre-scan evaluation indicating her history of some claustrophobia and anxiety. The patient was noted to be 5 ft 6 in tall and weighed 150 lbs and she otherwise had an unremarkable past medical history except for current shoulder pain and previous low back pain. She was on no maintenance medications and did not routinely use benzodiazepines

Because of the claustrophobia history the clinic nurse presented the pre-scan patient evaluation to subject physician Doe who was the attending radiologist at the NSDMG facility that day. Although the patient had been previously seen at that same facility there was no indication made on the pre-scan patient evaluation or history sheet of this patient having a previous MRI performed at the facility.

Dr. Doe, in his recorded physician interview on 5-28-08, confirmed he prescribed an oral dose of 20 mg. of Valium for purposes of sedation during the MRI study. He acknowledged that he was not aware the patient had been previously seen at the facility or that 7.5 mg. of Valium was previously prescribed and was highly effective for controlling the patient's anxiety. Dr. Doe confirmed that he did not physically examine or interview patient Smith before reaching a decision to prescribe 20 mg. of Valium.

Following the administration of the 20 mg. of Valium and before the MRI could be completed, patient Smith was removed from the scanner due to acute respiratory depression necessitating the administration of intravenous pharmacological agents including Romazicon, Narcan, D50W along with IV infusion and airway management with oxygen. EMTs were called and the patient was transported to the local community hospital for further care and observation.

MEDICAL ISSUES:

1. Initial evaluation of patient Smith prior to prescribing a benzodiazepine.

- **Standard of Care:**

  The standard of care for a radiologist prescribing a premedication to a patient requires that the radiologist review the relevant medical record and then determine the safety of

prescribing medication. This includes reviewing patient health history forms, pre-scan patient evaluations, and past treatment records relevant to the procedure being performed. It is not uncommon for the above to be reviewed without interviewing or seeing the patient.

- **Analysis:**

Dr. Doe did review the patient's pre-scan evaluation and nurses documented history. He was not aware the patient had a previous MRI at NSDMG and had been medicated with 7.5 mg. of Valium in 2006 with good results. Had Dr. Doe had access to the pre-medication history from the 2006 MRI he stated he would have used the same dosage. Review of the previously MRI report of the lumbar spine failed to indicate that any presedation medication was used. Therefore Dr. Doe relied on the current pre-scan evaluation & nurse's history and determined that because the patient indicated her level of claustrophobia was a 9/10 he would treat the patient with Valium prior to the MRI study.

- **Conclusion:**

Although Dr. Doe could have been more diligent in trying to determine if the patient had previously been pre-medicated for an MRI this does not reach a level of departure in the standard of care.

2. Use of 20 mg. of Valium for premedication dosing.

- **Standard of Care:**

The utilization of light sedation for purposes of successful MRI scanning is a common occurrence among radiologists on a daily basis and oral Valium is most commonly used with the dosage being predicated on the individual patient's clinical state, past history and level of anxiety. The dosage of po Valium recommended for adults ranges between 2 to 10 mg. for anxiety. Realizing the inherent limitations of administering light sedation in an outpatient setting, physician determination of a safe but effective dosing is as much an acquired clinical skill as it is a pharmacological science. One of the areas of concern with the use of oral sedatives in the outpatient setting is that there is often limited clinical information available for the physician upon which to base a treatment plan. Overall patient wellness, age, body habitus, and history of previous or recent benzodiazepam usage becomes of increased importance in making an informed decision about proper dose. The rule of thumb in such a matter is to use the most minimal dosage practical to achieve the desired effect of sedation. In this instance, community standard would require the use of somewhere between 2 and no more than 10 mg. of po Valium. In over twenty years of supervising MRI scans I have never

prescribed, heard or seen anyone prescribe 20 mg. as a single dose for outpatient sedation.

- **Analysis:**

  Dr. Doe did in fact authorize administration of 20 mg po Valium for this patient who had no routine use of benzodiazepines and had previously done well with 7.5 mg. of Valium for a similar procedure in 2006.

- **Conclusion:** There was a simple departure from the standard of care when Dr. Doe prescribed 20 mg. of Valium which clearly over-sedated the patient and caused significant respiratory depression. Had Dr. Doe been made aware that the patient previously had done well with 7.5 mg. of Valium as a pre-medication for an MRI his prescribing of 20 mg. would have represented an extreme departure in the standard of care.

3. Level of emergent treatment rendered by Dr. Doe.

- **Standard of Care:**

  The standard of care requires a radiologist to cease an elective diagnostic study if a patient is developing significant change in vital signs or life-threatening symptoms. In the case of respiratory depression, this requires removing the patient from the MRI scanner and providing an airway with oxygen and establishing an IV. In cases of suspected overdose of a benzodiazepine, it requires attempts to reverse that medication, establish an IV and giving other medications if the patient is unresponsive. It also requires activating 911 for EMT transport to a emergency department.

- **Analysis:**

  I fully agree with the emergent treatment rendered by Dr. Doe once Ms. Smith developed respiratory distress. He appropriately removed the patient from the MRI scanner, established an oral airway and oxygenated the patient. 911 was activated, an IV was started and appropriate medications to reverse the benzodiazepine over-dose were immediately administered.

- **Conclusion:**

  There was no departure in the standard of care in Dr. Doe's treatment of patient Smith's respiratory depression.

(Signature) Ray Roenten, M.D. (Date) 1/5/09
RAY ROENTEN, M.D.

COMPENSATION

The Medical Board will provide you with a form entitled Expert Reviewer's Statement of Services for use in billing for your expert reviewer services. You must complete a Statement of Services form for each case you review for the Medical Board. Sometimes it is necessary to complete more than one Statement of Services form during the course of a case. Failure to fill out the form completely will delay your compensation.

☐ **Initial Case Review**

You will be compensated at the rate of $150.00 per hour for your evaluation and report. Please record the hours worked on each case. When billing fractional time for less than a full hour please calculate the time to the nearest quarter hour. For example, if you work 1 hour and 22 or fewer minutes, the time billed should be 1.25 hours (or 1 1/4 hours), if you work 1 hour and 23 or more minutes, the time billed should be 1.5 hours (or 1 ½ hours), and so on through the hour.
The Medical Board keeps its accounts by fiscal year, which is July 1 through June 30. Please **do not** combine fiscal years on one form. Instead, use a separate form for each fiscal year.

☐ **Professional Competency Examination**

The reimbursement rate for professional competency examination (oral and written) is set at $150.00 per hour (not to exceed 4 hours or $600.00) for case review and question development, and $150.00 per hour (not to exceed 4 hours or $600.00) for the administration, scoring and any report preparation.

☐ **Mental or Physical Examination**

The reimbursement for the administration of a mental or physical evaluation is the usual and customary rate for the expert. However, please provide the investigator or medical consultant with an estimate of fees **prior** to conducting the mental or physical examination. You should not exceed the estimate unless pre-approved by the investigator.

☐ **Consultation with the deputy attorney general**

This includes any consultation, in person or by telephone, before the case is filed, while the action is pending, or in preparation for hearing. You will be compensated at the rate of $150.00 per hour.

☐ **Testimony at Hearing**

You will be compensated at the rate of $200.00 per hour for testimony, with the maximum fee allowable for a full day of testimony being $1600.00.

☐ **Miscellaneous Expenses**

Expenses incurred in performing expert review or acting as a witness should be itemized on a separate sheet of paper and summarized on the Statement of Services. See the current state reimbursement rate schedule in Section VI of the binder for other expenses including meals and lodging. Receipts must be attached for all travel and business expenses incurred in this category, other than mileage.

You will be authorized $75.00 per hour for actual drive time to attend a hearing or drive to a location (other than your regular business location) to administer a professional competency examination.

Please arrange all travels through the investigator and/or district office you are working with. The Medical Board staff will arrange the necessary flights, ground transportation and research/recommend hotel accommodations.