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10 **BEFORE THE**
11 **MEDICAL BOARD OF CALIFORNIA**
12 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

13 In the Matter of the First Amended Accusation
14 Against:

15 **ALFRED D. TROTTER, JR., M.D.**
16 **251 Landis Avenue, Suite 204**
Chula Vista, CA 92010

17 Physician's and Surgeon's Certificate No.
A21112,

18 Respondent.

Case No. 09-2013-235771
OAH No. 2015-090519

DEFAULT DECISION AND ORDER

[Gov. Code, §11520]

20 **FINDINGS OF FACT**

21 I. On or about December 23, 2014, Accusation No. 09-2013-235771 was filed against
22 Respondent Alfred D. Trotter Jr., M.D., before the Medical Board of California (Board). A true
23 and correct copy of Accusation No. 09-2013-235771 is attached as "Exhibit 1" to the separate
24 accompanying "Default Decision Evidence Packet" and incorporated by reference as if fully set
25 forth herein.¹

26 _____
27 ¹ The exhibits referred to herein, which are true and correct copies of the originals, are
28 contained in the separate accompanying "Default Decision Evidence Packet" and will be
identified by "Exhibit" followed by the specific exhibit number.

1 2. On December 23, 2014, Respondent was served by certified mail and first class mail
2 with a true and correct copy of Accusation No. 09-2013-235771, together with true and correct
3 copies of all other statutorily required documents, at his address of record on file with the Board
4 which was and is: 251 Landis Avenue, Suite 204, Chula Vista, California, 92010. ("Exhibit 2").
5 On January 9, 2015, the envelope containing Accusation No. 09-2013-235771 was returned to the
6 Board by the United States Postal Service and stamped with the notation "Not Deliverable As
7 Addressed / Unable to Forward." ("Exhibit 3"). On January 15, 2015, the Board re-served
8 Accusation No. 09-2013-235771 to Respondent. ("Exhibit 4"). Service of Accusation No. 09-
9 2013-235771 was effective as a matter of law under the provisions of Government Code section
10 11505, subdivision (c).

11 3. On February 9, 2015, Respondent filed a Notice of Defense and Response to
12 Accusation No. 09-2013-235771. ("Exhibit 5").

13 4. On June 16, 2015, First Amended Accusation No. 09-2013-235771 was filed against
14 Respondent by the Board. A true and correct copy of First Amended Accusation No. 09-2013-
15 235771 is attached as "Exhibit 6" to the separate accompanying "Default Decision Evidence
16 Packet" and incorporated by reference as if fully set forth herein

17 5. On June 16, 2015, Respondent was served by certified mail and first class mail with
18 a true and correct copy of First Amended Accusation No. 09-2013-235771, together with true and
19 correct copies of all other statutorily required documents, at his address of record on file with the
20 Board which was and is: 251 Landis Avenue, Suite 204, Chula Vista, California, 92010.
21 ("Exhibit 7") On July 31, 2015, the envelope containing First Amended Accusation No. 09-2013-
22 235771 was returned to the Board by the United States Postal Service and stamped with the
23 notation "Attempted Not Known." ("Exhibit 8"). The Board attempted to re-serve First
24 Amended Accusation No. 09-2013-235771 to Respondent a second time. However, on August
25 26, 2015, the envelope containing First Amended Accusation No. 09-2013-235771 was again
26 returned to the Board by the United States Postal Service and stamped with the notations
27 "Attempted Not Known" and "Forward Order Expired." ("Exhibit 9"). Service of First Amended

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1 Accusation No. 09-2013-235771 was effective as a matter of law under the provisions of
2 Government Code section 11505, subdivision (c).

3 6. On or about June 26, 1964, the Board issued Physician's and Surgeon's Certificate
4 No. A21112 to Alfred D. Trotter, Jr., M.D. (Respondent). The Physician's and Surgeon's
5 Certificate was in full force and effect at all times relevant to the charges and allegations
6 contained in both Accusation No. 09-2013-235771 and First Amended Accusation No. 09-2013-
7 235771, and expired on August 31, 2014, and has not been renewed. A true and correct copy of
8 Respondent's Certificate of Licensure is attached as "Exhibit 10" to the separate accompanying
9 "Default Decision Evidence Packet" and incorporated by reference as if fully set forth herein.

10 7. On October 27, 2014, the Board sent a letter to Respondent acknowledging receipt of
11 his September 15, 2014, application for voluntary surrender of license. The Board's letter
12 indicated that the Board had declined to approve Respondent's application due to an unresolved
13 pending disciplinary action. A true and correct copy of the Board's letter and the Respondent's
14 application for voluntary surrender with his supporting documentation are attached as "Exhibit
15 11" to the separate accompanying "Default Decision Evidence Packet" and incorporated by
16 reference as if fully set forth herein.

17 8. On June 6, 2016, Respondent filed a Notice of Withdrawal with the Board which
18 indicated that he was withdrawing his previous request for a hearing based upon Respondent's
19 belief and understanding that, the Board lacked jurisdiction over Respondent because he had
20 previously surrendered his license and sent it back to the Board. ("Exhibit 12").

21 9. Government Code section 11505, subdivision (c), states:

22 "...

23 "(c) The accusation ... and all accompanying information may be sent to the
24 respondent by any means selected by the agency. But no order adversely affecting
25 the rights of the respondent shall be made by the agency in any case unless the
26 respondent shall have been served personally or by registered mail as provided
27 herein, or shall have filed a notice of defense, or, as applicable, notice of
28 participation, or otherwise appeared. Service may be proved in the manner

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authorized in civil actions. Service by registered mail shall be effective if a statute or agency rule requires the respondent to file the respondent's address with the agency and to notify the agency of any change, and if a registered letter containing the accusation ... and accompanying material is mailed, addressed to the respondent at the latest address on file with the agency.

"..."

10. Government Code section 11506, subdivision (c), states:

"..."

"(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense or notice of participation, and the notice shall be deemed a specific denial of all parts of the accusation ... Failure to file a notice of defense or notice of participation shall constitute a waiver of respondent's right to a hearing ...

"..."

11. California Government Code section 11520 states, in pertinent part:

"(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

"..."

12. Pursuant to its authority under Government Code section 11520, the Board finds respondent is in default. The Board will take action without further hearing and, based on Respondent's express admissions by way of default and the evidence before it as contained in the separate accompanying "Default Decision Evidence Packet," finds that the charges and allegations in First Amended Accusation No. 09-2013-235771, and each of them, separately and severally, are true and correct.

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1 13. California Business and Professions Code section 118 provides:

2 "...

3 "(b) The suspension, expiration, or forfeiture by operation of law of a license
4 issued by a board in the department, or its suspension, forfeiture, or cancellation
5 by order of the board or by order of a court of law, or its surrender without the
6 written consent of the board, shall not, during any period in which it may be
7 renewed, restored, reissued, or reinstated, deprive the board of its authority to
8 institute or continue a disciplinary proceeding against the licensee upon any
9 ground provided by law or to enter an order suspending or revoking the license or
10 otherwise taking disciplinary action against the licensee on any such ground.

11 "..."

12 14. California Business and Professions Code section 2220 provides, in pertinent part,
13 that the Board may take action against all persons guilty of violating the provisions of Chapter 5
14 of Division 2 of that Code. All further section references are to the Business and Professions
15 Code (Code) unless otherwise indicated.

16 15. Code section 2227 provides that a licensee who is found guilty under the Medical
17 Practice Act may have his or her license revoked, suspended for a period not to exceed one (1)
18 year, placed on probation and required to pay the costs of probation monitoring, be publicly
19 reprimanded, or have such other action taken in relation to discipline as the Board deems proper.

20 16. Section 2234 of the Code states:

21 "The Division of Medical Quality² shall take action against any licensee who
22 is charged with unprofessional conduct. In addition to other provisions of this
23 article, unprofessional conduct includes, but is not limited to, the following:

24 "(a) Violating or attempting to violate, directly or indirectly, assisting in or

25
26 ² California Business and Professions Code section 2002, as amended and effective
27 January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in
28 the State Medical Practice Act (Bus. & Prof. Code, §§ 2000, *et seq.*) means the "Medical Board
of California," and references to the "Division of Medical Quality" and "Division of Licensing"
in the Act or any other provision of law shall be deemed to refer to the Board.

1 abetting the violation of, or conspiring to violate any provision of this chapter
2 [Chapter 5, the Medical Practice Act].

3 “(b) Gross negligence.

4 “(c) Repeated negligent acts. To be repeated, there must be two or more
5 negligent acts or omissions. An initial negligent act or omission followed by a
6 separate and distinct departure from the applicable standard of care shall constitute
7 repeated negligent acts.

8 “(1) An initial negligent diagnosis followed by an act or omission medically
9 appropriate for that negligent diagnosis of the patient shall constitute a single
10 negligent act.

11 “(2) When the standard of care requires a change in the diagnosis, act, or
12 omission that constitutes the negligent act described in paragraph (1), including,
13 but not limited to, a reevaluation of the diagnosis or a change in treatment, and the
14 licensee’s conduct departs from the applicable standard of care, each departure
15 constitutes a separate and distinct breach of the standard of care.

16 “(d) Incompetence.

17 “. . .”

18 17. Unprofessional conduct under Code section 2234 is conduct which breaches the rules
19 or ethical code of the medical profession, or conduct which is unbecoming to a member in good
20 standing or the medical profession, and which demonstrates an unfitness to practice medicine.
21 (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

22 18. Section 2266 of the Code states: The failure of a physician and surgeon to maintain
23 adequate and accurate records relating to the provision of services to their patients constitutes
24 unprofessional conduct.

25 19. Respondent has subjected his Physician’s and Surgeon’s Certificate No. A21112 to
26 disciplinary action under sections 2227 and 2334, as defined by section 2334, subdivision (b), of
27 the Code, in that he has committed gross negligence in his care and treatment of patients Y.B.,
28 E.H., C.J., A.O., A.M.R., and D.H., as more particularly alleged hereinafter:

1 20. Patient Y.B.

2 A. On or about September 8, 2011, patient Y.B. presented to respondent on
3 referral from Dr. P.C. for a vertigo evaluation. Patient Y.B. had a two (2) year
4 history of vertigo at the time she was seen by Respondent. Respondent diagnosed
5 chronic sinusitis,³ septal deviation and that patient Y.B.'s vertigo was secondary to
6 sinusitis. Respondent did not order audiological testing, an MRI, or vestibular
7 testing. Respondent did not document an appropriate history to support a
8 diagnosis of vertigo.

9 B. On or about October 12, 2011, patient Y.B. underwent a CT scan that did
10 not show any significant sinus disease.

11 C. On or about March 1, 2012, Respondent performed endoscopic sinus
12 surgery on patient Y.B. Subsequent to this surgery, patient Y.B. continued to
13 suffer from vertigo.

14 D. On or about July 24, 2012, patient Y.B. underwent another CT scan, which
15 now showed left sided maxillary and frontal sinus disease consistent with findings
16 expected in a patient who underwent sinus surgery in the absence of chronic sinusitis.

17 E. On or about November 6, 2012, Respondent performed revision
18 endoscopic sinus surgery on patient Y.B. This surgery was complicated by a left-
19 sided CSF⁴ leak. Respondent treated the CSF leak but did not admit patient Y.B.
20 to the hospital. Subsequent to this surgery, Respondent documented that patient
21 Y.B. continued to have chronic sinusitis.

22 F. On or about August 14, 2013, patient Y.B. underwent another
23 postoperative CT scan that revealed findings consistent with previous endoscopic
24 medial maxillectomy surgery, not endoscopic sinus surgery.

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27 ³ Inflammation of the paranasal sinuses.

28 ⁴ Cerebrospinal fluid.

1 G. Despite the absence of CT findings consistent with chronic sinusitis,
2 Respondent recommended that patient Y.B. undergo another sinus surgery, but
3 that surgery was ultimately cancelled.

4 H. Respondent committed gross negligence in his care and treatment of
5 patient Y.B. which included, but was not limited to, the following:

6 (i) Respondent failed to consider other etiologies or pursue further evaluation
7 of patient Y.B.'s vertigo; and

8 (ii) Respondent performed endoscopic sinus surgery on patient Y.B. without
9 an appropriate medical indication. ("Exhibit 13").

10 21. Patient E.H.

11 A. On or about June 14, 2011, patient E.H. presented to Respondent on
12 referral from Dr. H. for evaluation of right side ear pain, hearing loss and drainage.
13 Respondent diagnosed a large right-sided tympanic membrane perforation, chronic
14 sinusitis, and hearing loss secondary to chronic sinusitis and tympanic membrane
15 perforation.

16 B. On or about July 25, 2011, Respondent ordered a CT scan and requested
17 copies of patient E.H.'s most recent hearing examination.

18 C. On or about August 19, 2011, patient E.H. underwent a CT scan that did
19 not show any significant sinus disease. Respondent documented that the CT scan
20 revealed chronic sinusitis and recommended endoscopic sinus surgery.

21 D. On or about July 18, 2012, Respondent performed endoscopic sinus
22 surgery on patient E.H., which was complicated by right-sided CSF leak.
23 Respondent repaired the leak intra-operatively.

24 E. Respondent committed gross negligence in his care and treatment of
25 patient E.H. which included, but was not limited to, the following:

26 (i) Respondent failed to appropriately diagnose chronic sinusitis; and

27 (ii) Respondent performed endoscopic sinus surgery on patient E.H. without
28 an appropriate medical indication. ("Exhibit 13").

1 22. Patient C.J.

2 A. On or about October 5, 2010, patient C.J. presented to Respondent on
3 referral from Dr. M.T.T. for evaluation of right side ear tinnitus. Respondent
4 diagnosed chronic sinusitis with secondary Eustachian tube dysfunction leading to
5 tinnitus. Respondent prescribed Augmentin for one week and hypertonic saline
6 irrigation. Respondent ordered a CT scan that revealed some maxillary sinus
7 opacification bilaterally and a right-sided mucous retention cyst. Respondent
8 recommended endoscopic sinus surgery.

9 B. On or about December 27, 2010, Respondent performed endoscopic sinus
10 surgery on patient C.J. Post-operatively, Respondent documented continued
11 symptoms, diagnosed patient C.J. with chronic sinusitis, and recommended
12 revision endoscopic sinus surgery.

13 C. On or about January 11, 2012, Respondent performed a second endoscopic
14 sinus surgery on patient C.J., which was complicated by right-sided CSF leak.
15 Respondent attempted to repair the leak intra-operatively.

16 D. On or about January 12, 2012, Respondent documented an active right-
17 sided CSF leak. Respondent prescribed Amoxicillin for ten (10) days and
18 instructed patient C.J. to contact him if his condition worsened.

19 E. On or about January 18, 2012, Respondent saw patient C.J. post-
20 operatively and noted that the right-sided CSF leak had stopped.

21 F. On or about July 23, 2012, Respondent saw patient C.J. for anosmia⁵ and
22 congestion. Respondent ordered another CT scan.

23 G. On or about September 6, 2012, Respondent saw patient C.J. and
24 diagnosed chronic sinusitis. Respondent recommended another revision
25 endoscopic sinus surgery.

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28 ⁵ The inability to perceive odor or a lack of functioning olfaction.

1 H. Respondent committed gross negligence in his care and treatment of
2 patient C.J. which included, but was not limited to, the following:

3 (i) Respondent failed to appropriately diagnose chronic sinusitis;

4 (ii) Respondent performed endoscopic sinus surgery on patient C.J. without
5 an appropriate medical indication; and

6 (iii) Respondent failed to admit patient C.J. to the hospital after suffering a
7 right-sided CSF leak during endoscopic sinus surgery. ("Exhibit 13").

8 23. Patient A.O.

9 A. On or about October 27, 2011, patient A.O. presented to Respondent on
10 referral for a vertigo evaluation. Respondent noted additional symptoms of
11 bilateral tinnitus, migraine headaches, post nasal drip and pus inside patient A.O.'s
12 nose. Respondent diagnosed patient A.O. with chronic sinusitis. Respondent
13 ordered hypertonic saline solution and Afrin spray for treatment of patient A.O.'s
14 diagnosis of chronic sinusitis. Respondent did not order audiological testing, an
15 MRI, or vestibular testing. Respondent did not document an appropriate history to
16 support a diagnosis of vertigo.

17 B. On or about December 6, 2011, patient A.O. underwent a CT scan that did
18 not show any significant sinus disease. Despite these negative findings,
19 Respondent recommended endoscopic sinus surgery.

20 C. On or about March 6, 2012, Respondent performed endoscopic sinus
21 surgery on patient A.O., which was complicated by right-sided CSF leak.
22 Respondent attempted to repair the leak intra-operatively.

23 D. On or about March 7, 2012, Respondent saw patient A.O. postoperatively
24 and noted signs of an active right-sided CSF leak. Respondent recommended
25 saline irrigation and Afrin spray as needed.

26 E. Patient A.O. developed postoperative nasal polyps as a result of
27 Respondent's endoscopic sinus surgery.

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1 F. Respondent committed gross negligence in his care and treatment of
2 patient A.O. which included, but was not limited to, the following:

3 (i) Respondent failed to consider other etiologies or pursue further evaluation
4 of patient A.O.'s vertigo;

5 (ii) Respondent failed to appropriately diagnose chronic sinusitis; and

6 (iii) Respondent failed to admit patient A.O. to the hospital after suffering a
7 CSF leak during endoscopic sinus surgery. ("Exhibit 13").

8 24. Patient A.M.R.

9 A. On or about September 19, 2011, patient A.M.R. presented to Respondent
10 on referral from Dr. G. for an evaluation of eye tearing for eight (8) months.
11 Respondent documented a history suggestive of sinus disease. Respondent
12 diagnosed chronic sinusitis, septal deviation, and allergic rhinitis. Respondent
13 ordered hypertonic saline solution and Claritin for treatment of patient A.M.R.'s
14 diagnosis of chronic sinusitis and allergic rhinitis.

15 B. On or about February 23, 2012, patient A.M.R. presented to Respondent
16 with continuing symptoms. Respondent ordered a CT scan that showed some
17 sinus disease in the left maxillary sinus. Respondent ordered the use of Flonase
18 and Afrin spray every other day. Respondent also recommended endoscopic sinus
19 surgery.

20 C. On or about August 1, 2012, Respondent performed endoscopic sinus
21 surgery on patient A.M.R.

22 D. During the six (6) months post operative period, Respondent saw patient
23 A.M.R. several times. Initially, Respondent noted "fairly heavy" polyps in the
24 bilateral nasal cavities. Respondent noted the polyps improved during the six (6)
25 month postoperative period.

26 E. Respondent committed gross negligence in his care and treatment of
27 patient A.M.R. which included, but was not limited to, the following:

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1 (i) Respondent performed endoscopic sinus surgery on patient A.M.R.
2 without an appropriate medical indication; and

3 (ii) Respondent recommended the chronic use of Afrin spray. ("Exhibit 13").

4 25. Patient D.H.

5 A. On or about January 30, 2013, patient D.H. saw Respondent for an
6 evaluation of decreased hearing in her right ear. Respondent diagnosed patient
7 D.H. with right sided sensorineural "deafness" and chronic sinusitis. Respondent
8 recommended a follow up appointment in one month, hypertonic saline, and Afrin
9 spray for the sinusitis and an MRI to rule out hearing loss caused by a
10 schwannoma.⁶

11 B. On or about March 5, 2013, patient D.H. underwent a CT scan because the
12 attending radiologist felt that patient D.H.'s ventriculoperitoneal (VP) shunt⁷ from a
13 previous intracranial aneurysm surgery was a contraindication for an MRI. The CT
14 indicated patient D.H. had normal sinuses and no deviation of her nasal septum.

15 C. On or about March 7, 2013, Respondent saw patient D.H. and documented
16 that the cause of patient D.H.'s right sided deafness had not been delineated and
17 that she continued to have nasal congestion and post nasal drip. Respondent
18 ordered an audiogram and recommended continued use of saline spray and a
19 follow up appointment in one month.

20 D. On or about March 18, 2013, patient D.H. underwent diagnostic
21 audiological testing that revealed her hearing was symmetrical and normal.

22 E. On or about April 18, 2013, Respondent saw patient D.H. and documented
23 that all of her symptoms had resolved with nasal saline and Afrin sprays.
24 Respondent diagnosed patient D.H. with chronic sinusitis despite the fact that
25 patient D.H.'s previous CT scan was negative for sinusitis.

26
27 ⁶ A benign nerve sheath tumor.

28 ⁷ A device used to relieve pressure from the brain caused by fluid accumulation.

1 F. On or about July 2, 2013, patient D.H. returned to Respondent with sinus
2 complaints and indicated the nasal saline and Afrin sprays were no longer helping.
3 Respondent reviewed the previous CT scan and documented that patient D.H.'s
4 sinuses were normal. Respondent diagnosed chronic sinusitis and scheduled
5 patient D.H. for endoscopic sinus surgery with possible submucous resection
6 septoplasty.⁸

7 G. On or about August 7, 2013, Respondent performed a pre-operative
8 history and physical on patient D.H. that did not document a finding that patient
9 D.H. had a deviated septum.

10 H. On or about August 21, 2013, Respondent documented a pre-operative
11 history and physical on patient D.H. that noted gross swelling of the turbinates.⁹
12 Respondent never offered any medical or surgical intervention for this condition
13 other than nasal saline and Afrin sprays.

14 I. On or about August 21, 2013, Respondent performed a submucous
15 resection septoplasty surgery on patient D.H. at the Sharp Chula Vista Surgery
16 Center. Respondent then started endoscopic sinus surgery on patient D.H.'s left
17 side sinuses by removing the uncinate process and the middle turbinates.
18 Respondent then resected the ethmoid sinuses and proceeded with the enlargement
19 of the left maxillary sinus window. At that point in the procedure, patient D.H.
20 suffered rapid bleeding and blood loss. Respondent decided to pack patient D.H.'s
21 left nose with numerous Codman pledgets¹⁰ to control the bleeding. Respondent
22 then performed endoscopic sinus surgery on the ethmoid, maxillary and sphenoid
23 sinuses on the right side. After completing surgery on the right side, Respondent
24 decided not to remove the Codman pledgets and to leave patient D.H. intubated for

25 ⁸ A surgical procedure to correct a deviated nasal septum.

26 ⁹ Long, narrow and curled bone shelves (shaped like an elongated seashell) that protrudes
27 into the breathing passage of the nose.

28 ¹⁰ Small pads used to absorb fluids during surgery.

1 transfer to the Sharp Chula Vista Emergency Department for evaluation and
2 admission to the Intensive Care Unit (ICU) and for possible blood transfusions.
3 Respondent noted in his operative notes that he would determine the cause of the
4 bleeding after patient D.H. received blood transfusions.

5 J. On or about August 22, 2013, patient D.H. was seen by Dr. A.M., an
6 otolaryngologist. Dr. A.M. ordered an angiogram that revealed a pseudoaneurysm
7 of the distal internal maxillary artery, which appeared to be the source of patient
8 D.H.'s bleeding.

9 K. On or about August 24, 2013, Dr. A.M. performed surgery on patient
10 D.H., during which he removed the Codman pledgets from patient D.H.'s right and
11 left sinuses, and identified and treated two left maxillary sinusotomies that he
12 believed to be the source of patient D.H.'s bleeding.

13 L. On or about August 25, 2013, patient D.H. was transferred out of the ICU.

14 M. On or about August 29, 2013, patient D.H. was discharged from the
15 hospital.

16 N. On or about September 16, 2013, patient D.H. saw Respondent for a
17 clinical visit. Respondent documented that patient D.H. was not performing
18 adequate post-operative care of her sinuses and recommended daily saline rinses
19 and Afrin use every other day.

20 O. On or about October 14, 2013, patient D.H. saw Respondent for a clinical
21 visit. Respondent recommended hypertonic saline rinses six (6) to eight (8) times
22 per day for the next six (6) months.

23 P. Respondent committed gross negligence in his care and treatment of
24 patient D.H., which included, but was not limited to, the following:

25 (i) Respondent failed to formulate and/or implement a plan to address patient
26 D.H.'s intraoperative bleeding;

27 (ii) Respondent failed to obtain appropriate consultation to determine the
28 source of patient D.H.'s intraoperative bleeding;

1 (iii) Respondent performed a septoplasty on patient D.H. without medical
2 indication;

3 (iv) Respondent used an inappropriately large number of Codman pledgets
4 during patient D.H.'s surgery;

5 (v) Respondent left Codman pledgets in place post-operatively; and

6 (vi) Respondent recommended the chronic use of Afrin spray. ("Exhibit 13").

7 26. Respondent has further subjected his Physician's and Surgeon's Certificate
8 No. A21112 to disciplinary action under sections 2227 and 2234, as defined in section
9 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care
10 and treatment of patients Y.B., E.H., C.J., A.O., A.M.R., and D.H., as more particularly
11 alleged hereinafter:

12 27. Patient Y.B.

13 A. Paragraphs 20A through 20H, above, are hereby incorporated by reference
14 and realleged as if fully set forth herein.

15 B. Respondent committed repeated negligent acts in his care and treatment of
16 patient Y.B. which included, but was not limited to, the following:

17 (i) Respondent failed to admit patient Y.B. to the hospital after she suffered a
18 CSF leak during endoscopic sinus surgery. ("Exhibit 13").

19 28. Patient E.H.

20 A. Paragraphs 21A through 21E, above, are hereby incorporated by reference
21 and realleged as if fully set forth herein.

22 B. Respondent committed repeated negligent acts in his care and treatment of
23 patient E.H. which included, but was not limited to, the following:

24 (i) Respondent failed to order audiological testing for patient E.H.;

25 (ii) Respondent failed to consider tympanoplasty surgery; and

26 (iii) Respondent failed to admit patient E.H. to the hospital after she suffered
27 a right-sided CSF leak during endoscopic sinus surgery. ("Exhibit 13").

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1 29. Patient C.J.

2 A. Paragraphs 22A through 22H, above, are hereby incorporated by reference
3 and realleged as if fully set forth herein.

4 B. Respondent committed repeated negligent acts in his care and treatment of
5 patient C.J. which included, but was not limited to, the following:

6 (i) Respondent failed to properly diagnose and/or treat patient C.J.'s tinnitus.
7 ("Exhibit 13").

8 30. Patient A.O.

9 A. Paragraphs 23A through 23F, above, are hereby incorporated, by reference
10 and realleged as if fully set forth herein. ("Exhibit 13").

11 31. Patient A.M.R.

12 A. Paragraphs 24A through 24E, above, are hereby incorporated by reference
13 and realleged as if fully set forth herein.

14 B. Respondent committed repeated negligent acts in his care and treatment of
15 patient A.M.R. which included, but was not limited to, the following:

16 (i) Respondent failed to properly diagnose and/or treat patient A.M.R.'s
17 tearing complaints. ("Exhibit 13").

18 32. Patient D.H.

19 A. Paragraphs 25A through 25P, above, are hereby incorporated by reference
20 and realleged as if fully set forth herein.

21 B. Respondent committed repeated negligent acts in his care and treatment of
22 patient D.H. which included, but was not limited to, the following:

23 (i) Respondent removed patient D.H.'s bilateral middle turbinates without a
24 medical indication;

25 (ii) Respondent failed to appropriately treat patient D.H.'s inferior turbinate
26 hypertrophy; and

27 (ii) Respondent failed to order a timely angiogram to assess patient D.H.'s
28 reported hearing loss. ("Exhibit 13").

1 (b) Engaged in repeated negligent acts in his care and treatment of patients
2 Y.B, E.H., C. J., A.O., A.M.R., and D.H., in violation of Code section 2234,
3 subdivision (c);

4 (c) Demonstrated incompetence in his care and treatment of patients Y.B, E.H.,
5 C. J., A.O., A.M.R., and D.H., in violation of Code section 2234, subdivision (d); and

6 (d) Failed to maintain adequate and accurate records in connection with his
7 care and treatment of patients Y.B, E.H., C. J., A.O., A.M.R., and D.H., in
8 violation of Code section 2266.

9
10 **ORDER**

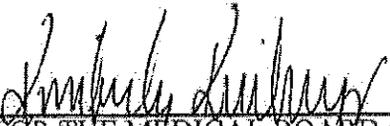
11 IT IS HEREBY ORDERED that:

12 Physician's and Surgeon's Certificate No. A21112, heretofore issued by the Board to
13 Respondent Alfred D. Trotter, Jr., M.D., is hereby revoked for each of the violations, separately
14 and severally, of California Business and Professions Code found in the Determination of Issues,
15 above.

16 Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a
17 written motion requesting that the Decision be vacated and stating the grounds relied on within
18 seven (7) days after service of the Decision on Respondent. The agency in its discretion may
19 vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

20 This Decision shall become effective on January 4, 2017.

21 It is so ORDERED December 5, 2016.

22
23 
24 FOR THE MEDICAL BOARD OF CALIFORNIA
25 KIMBERLY KIRCHMEYER
EXECUTIVE DIRECTOR

26 Attachment:

27 Default Decision Evidence Packet

28 SD2014708134 / Doc.No.81429165

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO June 16 20 15
BY R. FIRDAYS ANALYST

10 BEFORE THE
11 MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
12 STATE OF CALIFORNIA

13 In the Matter of the First Amended Accusation
Against:

Case No. 09-2013-235771

14 ALFRED D. TROTTER, JR., M.D.
15 251 Landis Avenue, Suite 204
Chula Vista, CA 92010

FIRST AMENDED ACCUSATION

16 Physician and Surgeon's Certificate No.
17 A 21112,

18 Respondent.

19
20 Complainant alleges:

21 PARTIES

22 1. Kimberly Kirchmeyer (complainant) brings this First Amended Accusation solely in
23 her official capacity as the Executive Director of the Medical Board of California, Department of
24 Consumer Affairs.

25 2. On or about June 26, 1964, the Medical Board of California issued Physician's and
26 Surgeon's Certificate No. A 21112 to Alfred D. Trotter, Jr., M.D. (respondent). The Physician's
27 and Surgeon's Certificate was in full force and effect at all times relevant to the charges and
28 allegations brought herein and expired on August 31, 2014, and has not been renewed.

1 5. Section 2234 of the Code states:

2 "The board shall take action against any licensee who is charged with unprofessional
3 conduct. In addition to other provisions of this article, unprofessional conduct includes, but
4 is not limited to, the following:

5 "(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting
6 the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the
7 Medical Practice Act].

8 "(b) Gross negligence.

9 "(c) Repeated negligent acts. To be repeated, there must be two or more negligent
10 acts or omissions. An initial negligent act or omission followed by a separate and distinct
11 departure from the applicable standard of care shall constitute repeated negligent acts.

12 "(1) An initial negligent diagnosis followed by an act or omission medically
13 appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

14 "(2) When the standard of care requires a change in the diagnosis, act, or omission
15 that constitutes the negligent act described in paragraph (1), including, but not limited to, a
16 reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs
17 from the applicable standard of care, each departure constitutes a separate and distinct
18 breach of the standard of care.

19 "(d) Incompetence.

20 "..."

21 6. Section 2266 of the Code states:

22 "The failure of a physician and surgeon to maintain adequate and accurate records
23 relating to the provision of services to their patients constitutes unprofessional conduct."

24 **FIRST CAUSE FOR DISCIPLINE**

25 (Gross Negligence)

26 7. Respondent has subjected his Physician's and Surgeon's Certificate Number
27 A 21112 to disciplinary action under sections 2227 and 2234, as defined in section 2234,
28 subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of

1 patients Y.B., E.H., C.J., A.O., A.M.R., and D.H., as more particularly alleged hereinafter:

2 Patient Y.B.

3 8. On or about September 8, 2011, patient Y.B. presented to respondent on referral from
4 Dr. P.C. for a vertigo evaluation. Patient Y.B. had a two (2) year history of vertigo at the time
5 she was seen by respondent. Respondent diagnosed chronic sinusitis,¹ septal deviation and that
6 patient Y.B.'s vertigo was secondary to sinusitis. Respondent did not order audiological testing,
7 an MRI, or vestibular testing. Respondent did not document an appropriate history to support a
8 diagnosis of vertigo.

9 9. On or about October 12, 2011, patient Y.B. underwent a CT scan that did not show
10 any significant sinus disease.

11 10. On or about March 1, 2012, respondent performed endoscopic sinus surgery on
12 patient Y.B. Subsequent to this surgery, patient Y.B. continued to suffer from vertigo.

13 11. On or about July 24, 2012, patient Y.B. underwent another CT scan which now
14 showed left sided maxillary and frontal sinus disease consistent with findings expected in a
15 patient who underwent sinus surgery in the absence of chronic sinusitis.

16 12. On or about November 6, 2012, respondent performed revision endoscopic sinus
17 surgery on patient Y.B. This surgery was complicated by a left-sided CSF² leak. Respondent
18 treated the CSF leak but did not admit patient Y.B. to the hospital. Subsequent to this surgery,
19 respondent documented that patient Y.B. continued to have chronic sinusitis.

20 13. On or about August 14, 2013, patient Y.B. underwent another post operative CT scan
21 that revealed findings consistent with previous endoscopic medial maxillectomy surgery, not
22 endoscopic sinus surgery.

23 14. Despite the absence of CT findings consistent with chronic sinusitis, respondent
24 recommended that patient Y.B. undergo another sinus surgery, but that surgery was ultimately
25 cancelled.

26
27 ¹ Inflammation of the paranasal sinuses.

28 ² Cerebrospinal fluid.

1 15. Respondent committed gross negligence in his care and treatment of patient Y.B.
2 which included, but was not limited to, the following:

3 (a) Respondent failed to consider other etiologies or pursue further evaluation of
4 patient Y.B.'s vertigo; and

5 (b) Respondent performed endoscopic sinus surgery on patient Y.B. without an
6 appropriate medical indication.

7 Patient E.H.

8 16. On or about June 14, 2011, patient E.H. presented to respondent on referral from
9 Dr. H. for evaluation of right side ear pain, hearing loss and drainage. Respondent diagnosed a
10 large right-sided tympanic membrane perforation, chronic sinusitis, and hearing loss secondary to
11 chronic sinusitis and tympanic membrane perforation.

12 17. On or about July 25, 2011, respondent ordered a CT scan and requested copies
13 of patient E.H.'s most recent hearing examination.

14 18. On or about August 19, 2011, patient E.H. underwent a CT scan that did not show
15 any significant sinus disease. Respondent documented that the CT scan revealed chronic sinusitis
16 and recommended endoscopic sinus surgery.

17 19. On or about July 18, 2012, respondent performed endoscopic sinus surgery on patient
18 E.H. which was complicated by right-sided CSF leak. Respondent repaired the leak intra-
19 operatively.

20 20. Respondent committed gross negligence in his care and treatment of patient E.H.
21 which included, but was not limited to, the following:

22 (a) Respondent failed to appropriately diagnose chronic sinusitis; and

23 (b) Respondent performed endoscopic sinus surgery on patient E.H. without an
24 appropriate medical indication.

25 Patient C.J.

26 21. On or about October 5, 2010, patient C.J. presented to respondent on referral from
27 Dr. M.T.T. for evaluation of right side ear tinnitus. Respondent diagnosed chronic sinusitis with
28 secondary eustachian tube dysfunction leading to tinnitus. Respondent prescribed Augmentin for

1 one week and hypertonic saline irrigation. Respondent ordered a CT scan that revealed some
2 maxillary sinus opacification bilaterally and a right-sided mucous retention cyst. Respondent
3 recommended endoscopic sinus surgery.

4 22. On or about December 27, 2010, respondent performed endoscopic sinus surgery on
5 patient C.J. Post-operatively, respondent documented continued symptoms, diagnosed patient
6 C.J. with chronic sinusitis, and recommended revision endoscopic sinus surgery.

7 23. On or about January 11, 2012, respondent performed a second endoscopic sinus
8 surgery on patient C.J. which was complicated by right-sided CSF leak. Respondent attempted to
9 repair the leak intra-operatively.

10 24. On or about January 12, 2012, respondent documented an active right-sided CSF
11 leak. Respondent prescribed Amoxicillin for ten (10) days and instructed patient C.J. to contact
12 him if his condition worsened.

13 25. On or about January 18, 2012, respondent saw patient C.J. post-operatively and noted
14 that the right-sided CSF leak had stopped.

15 26. On or about July 23, 2012, respondent saw patient C.J. for anosmia³ and congestion.
16 Respondent ordered another CT scan.

17 27. On or about September 6, 2012, respondent saw patient C.J. and diagnosed chronic
18 sinusitis. Respondent recommended another revision endoscopic sinus surgery.

19 28. Respondent committed gross negligence in his care and treatment of patient C.J.
20 which included, but was not limited to, the following:

21 (a) Respondent failed to appropriately diagnose chronic sinusitis;

22 (b) Respondent performed endoscopic sinus surgery on patient C.J. without an
23 appropriate medical indication; and

24 (c) Respondent failed to admit patient C.J. to the hospital after suffering a right-
25 sided CSF leak during endoscopic sinus surgery.

26 ///

27 _____
28 ³ The inability to perceive odor or a lack of functioning olfaction.

1 Patient A.O.

2 29. On or about October 27, 2011, patient A.O. presented to respondent on referral for a
3 vertigo evaluation. Respondent noted additional symptoms of bilateral tinnitus, migraine
4 headaches, post nasal drip and pus inside patient A.O.'s nose. Respondent diagnosed patient
5 A.O. with chronic sinusitis. Respondent ordered hypertonic saline solution and Afrin spray for
6 treatment of patient A.O.'s diagnosis of chronic sinusitis. Respondent did not order audiological
7 testing, an MRI, or vestibular testing. Respondent did not document an appropriate history to
8 support a diagnosis of vertigo.

9 30. On or about December 6, 2011, patient A.O. underwent a CT scan that did not show
10 any significant sinus disease. Despite these negative findings, respondent recommended
11 endoscopic sinus surgery.

12 31. On or about March 6, 2012, respondent performed endoscopic sinus surgery on
13 patient A.O. which was complicated by right-sided CSF leak. Respondent attempted to repair the
14 leak intra-operatively.

15 32. On or about March 7, 2012, respondent saw patient A.O. postoperatively and noted
16 signs of an active right-sided CSF leak. Respondent recommended saline irrigation and Afrin
17 spray as needed.

18 33. Patient A.O. developed post operative nasal polyps as a result of respondent's
19 endoscopic sinus surgery.

20 34. Respondent committed gross negligence in his care and treatment of patient A.O.
21 which included, but was not limited to, the following:

22 (a) Respondent failed to consider other etiologies or pursue further evaluation of
23 patient A.O.'s vertigo;

24 (b) Respondent failed to appropriately diagnose chronic sinusitis; and

25 (c) Respondent failed to admit patient A.O. to the hospital after suffering a CSF
26 leak during endoscopic sinus surgery.

27 Patient A.M.R.

28 35. On or about September 19, 2011, patient A.M.R. presented to respondent on referral

1 from Dr. G. for an evaluation of eye tearing for eight (8) months. Respondent documented a
2 history suggestive of sinus disease. Respondent diagnosed chronic sinusitis, septal deviation, and
3 allergic rhinitis. Respondent ordered hypertonic saline solution and Claritin for treatment of
4 patient A.M.R.'s diagnosis of chronic sinusitis and allergic rhinitis.

5 36. On or about February 23, 2012, patient A.M.R. presented to respondent with
6 continuing symptoms. Respondent ordered a CT scan that showed some sinus disease in the left
7 maxillary sinus. Respondent ordered the use of Flonase and Afrin spray every other day.
8 Respondent also recommended endoscopic sinus surgery.

9 37. On or about August 1, 2012, respondent performed endoscopic sinus surgery on
10 patient A.M.R.

11 38. During the six (6) months post operative period, respondent saw patient A.M.R.
12 several times. Initially, respondent noted "fairly heavy" polyps in the bilateral nasal cavities.
13 Respondent noted the polyps improved during the six (6) month post operative period.

14 39. Respondent committed gross negligence in his care and treatment of patient A.M.R.
15 which included, but was not limited to, the following:

16 (a) Respondent performed endoscopic sinus surgery on patient A.M.R. without an
17 appropriate medical indication; and

18 (b) Respondent recommended the chronic use of Afrin spray.

19 Patient D.H.

20 40. On or about January 30, 2013, patient D.H. saw respondent for an evaluation of
21 decreased hearing in her right ear. Respondent diagnosed patient D.H. with right sided
22 sensorineural "deafness" and chronic sinusitis. Respondent recommended a follow up
23 appointment in one month, hypertonic saline and Afrin spray for the sinusitis and an MRI to rule
24 out hearing loss caused by a schwannoma.⁴

25
26
27 ⁴ A benign nerve sheath tumor.

1 41. On or about March 5, 2013, patient D.H. underwent a CT scan because the attending
2 radiologist felt that patient D.H.'s ventriculoperitoneal (VP) shunt⁵ from a previous intracranial
3 aneurysm surgery was a contraindication for an MRI. The CT indicated patient D.H. had normal
4 sinuses and no deviation of her nasal septum.

5 42. On or about March 7, 2013, respondent saw patient D.H. and documented that the
6 cause of patient D.H.'s right sided deafness had not been delineated and that she continued to
7 have nasal congestion and post nasal drip. Respondent ordered an audiogram and recommended
8 continued use of saline spray and a follow up appointment in one month.

9 43. On or about March 18, 2013, patient D.H. underwent diagnostic audiological testing
10 that revealed her hearing was symmetrical and normal.

11 44. On or about April 18, 2013, respondent saw patient D.H. and documented that all of
12 her symptoms had resolved with nasal saline and Afrin sprays. Respondent diagnosed patient
13 D.H. with chronic sinusitis despite the fact that patient D.H.'s previous CT scan was negative for
14 sinusitis.

15 45. On or about July 2, 2013, patient D.H. returned to respondent with sinus complaints
16 and indicated the nasal saline and Afrin sprays were no longer helping. Respondent reviewed the
17 previous CT scan and documented that patient D.H.'s sinuses were normal. Respondent
18 diagnosed chronic sinusitis and scheduled patient D.H. for endoscopic sinus surgery with possible
19 submucous resection septoplasty.⁶

20 46. On or about August 7, 2013, respondent performed a pre-operative history and
21 physical on patient D.H. that did not document a finding that patient D.H. had a deviated septum.

22 47. On or about August 21, 2013, respondent documented a pre-operative history and
23 physical on patient D.H. that noted gross swelling of the turbinates.⁷ Respondent never offered
24

25 ⁵ A device used to relieve pressure from the brain caused by fluid accumulation.

26 ⁶ A surgical procedure to correct a deviated nasal septum.

27 ⁷ Long, narrow and curled bone shelves (shaped like an elongated sea-shell) that
28 protrudes into the breathing passage of the nose.

1 any medical or surgical intervention for this condition other than nasal saline and Afrin sprays.
2 48. On or about August 21, 2013, respondent performed a submucous resection
3 septoplasty surgery on patient D.H. at the Sharp Chula Vista Surgery Center. Respondent then
4 started endoscopic sinus surgery on patient D.H.'s left side sinuses by removing the uncinate
5 process and the middle turbinates. Respondent then resected the ethmoid sinuses and proceeded
6 with the enlargement of the left maxillary sinus window. At that point in the procedure, patient
7 D.H. suffered rapid bleeding and blood loss. Respondent decided to pack patient D.H.'s left nose
8 with numerous Codman pledgets⁸ to control the bleeding. Respondent then performed
9 endoscopic sinus surgery on the ethmoid, maxillary and sphenoid sinuses on the right side. After
10 completing surgery on the right side, respondent decided not to remove the Codman pledgets and
11 to leave patient D.H. intubated for transfer to the Sharp Chula Vista Emergency Department for
12 evaluation and admission to the Intensive Care Unit (ICU) and for possible blood transfusions.
13 Respondent noted in his operative notes that he would determine the cause of the bleeding after
14 patient D.H. received blood transfusions.

15 49. On or about August 22, 2013, patient D.H. was seen by Dr. A.M., an
16 otolaryngologist. Dr. A.M. ordered an angiogram that revealed a pseudoaneurysm of the distal
17 internal maxillary artery which appeared to be the source of patient D.H.'s bleeding.

18 50. On or about August 24, 2013, Dr. A.M. performed surgery on patient D.H., during
19 which he removed the Codman pledgets from patient D.H.'s right and left sinuses, and identified
20 and treated two left maxillary sinusotomies that he believed to be the source of patient D.H.'s
21 bleeding.

22 51. On or about August 25, 2013, patient D.H. was transferred out of the ICU.

23 52. On or about August 29, 2013, patient D.H. was discharged from the hospital.

24 53. On or about September 16, 2013, patient D.H. saw respondent for a clinical visit.
25 Respondent documented that patient D.H. was not performing adequate post-operative care of her
26 sinuses and recommended daily saline rinses and Afrin use every other day.

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28 ⁸ Small pads used to absorb fluids during surgery.

1 (a) Respondent failed to admit patient Y.B. to the hospital after she suffered a CSF
2 leak during endoscopic sinus surgery.

3 Patient E.H.

4 59. Paragraphs 16 through 20, above, are hereby incorporated by reference and realleged
5 as if fully set forth herein.

6 60. Respondent committed repeated negligent acts in his care and treatment of patient
7 E.H. which included, but was not limited to, the following:

8 (a) Respondent failed to order audiological testing for patient E.H.;

9 (b) Respondent failed to consider tympanoplasty surgery; and

10 (c) Respondent failed to admit patient E.H. to the hospital after she suffered a
11 right-sided CSF leak during endoscopic sinus surgery.

12 Patient C.J.

13 61. Paragraphs 21 through 28, above, are hereby incorporated by reference and realleged
14 as if fully set forth herein.

15 62. Respondent committed repeated negligent acts in his care and treatment of patient
16 C.J. which included, but was not limited to, the following:

17 (a) Respondent failed to properly diagnose and/or treat patient C.J.'s tinnitus.

18 Patient A.O.

19 63. Paragraphs 29 through 34, above, are hereby incorporated by reference and realleged
20 as if fully set forth herein.

21 Patient A.M.R.

22 64. Paragraphs 35 through 39, above, are hereby incorporated by reference and realleged
23 as if fully set forth herein.

24 65. Respondent committed repeated negligent acts in his care and treatment of patient
25 A.M.R. which included, but was not limited to, the following:

26 (a) Respondent failed to properly diagnose and/or treat patient A.M.R.'s tearing
27 complaints.

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Patient D.H.

66. Paragraphs 40 through 55, above, are hereby incorporated by reference and realleged as if fully set forth herein.

67. Respondent committed repeated negligent acts in his care and treatment of patient D.H. which included, but was not limited to, the following:

(a) Respondent removed patient D.H.'s bilateral middle turbinates without a medical indication;

(b) Respondent failed to appropriately treat patient D.H.'s inferior turbinate hypertrophy; and

(c) Respondent failed to order a timely angiogram to assess patient D.H.'s reported hearing loss.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

68. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 21112 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he has demonstrated incompetence in his care and treatment of patients Y.B., E.H., C.J., A.O., A.M.R., and D.H., as more particularly alleged hereinafter:

69. Paragraphs 7 through 67, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

70. Respondent has further subjected his Physician's and Surgeon's Certificate Number A 21112 to disciplinary action under section 2227 and 2234, as defined in section 2266, of the Code, in that he failed to maintain adequate and accurate records in connection with his care and treatment of patients Y.B., E.H., C.J., A.O., A.M.R., and D.H., as more particularly alleged hereinafter:

71. Paragraphs 7 through 67, above, are hereby incorporated by reference and realleged as if fully set forth herein.

1 PRAYER

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

- 4 1. Revoking or suspending Physician's and Surgeon's Certificate Number
5 A 21112, issued to respondent Alfred D. Trotter, Jr., M.D.;
- 6 2. Revoking, suspending or denying approval of respondent Alfred D. Trotter,
7 Jr., M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;
- 8 3. Ordering respondent Alfred D. Trotter, Jr., M.D., to pay the Medical Board of
9 California, if placed on probation, the costs of probation monitoring; and,
- 10 4. Taking such other and further action as deemed necessary and proper.

11 DATED: June 16, 2015


12 KIMBERLY KIRCHMEYER
13 Executive Director
14 Medical Board of California
15 Department of Consumer Affairs
16 State of California
17 Complainant