

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

**In the Matter of the Accusation
Against:**

FRED HENRY RUNDALL, M.D.

**Physician's and Surgeon's Certificate
No. G50482**

No. 17-2010-205130

ORDER FOR LICENSE SURRENDER DURING PROBATION

The above named respondent was placed on five (5) years' probation effective December 31, 2013. Pursuant to the terms and conditions of the probationary order, the respondent elected to surrender his license effective November 10, 2016.

WHEREFORE, THE ABOVE IS ORDERED by the Medical Board of California.

So ordered January 26, 2017.

MEDICAL BOARD OF CALIFORNIA



Dev GnanaDev, President

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

In the Matter of the Accusation Against:

**Fred Henry Rundall, M.D.
39478 Butterfly Dr. NE
Yucaipa, CA 92399**

**Physician's and Surgeon's
Certificate No. G50482**

Respondent.

Case No. 17-2010-205130

**AGREEMENT FOR
SURRENDER OF LICENSE**

TO ALL PARTIES:

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings, that the following matters are true:

1. Complainant, Kimberly Kirchmeyer, is the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. Fred Henry Rundall, M.D., ("Respondent") has carefully read and fully understands the effect of this Agreement.

3. Respondent understands that by signing this Agreement he is enabling the Board to issue this order accepting the surrender of license without further process. Respondent understands and agrees that Board staff and counsel for complainant may communicate directly with the Board regarding this Agreement, without notice to or participation by Respondent. The Board will not be disqualified from further action in this matter by virtue of its consideration of this Agreement.

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1 4. Respondent acknowledges there is current disciplinary action against his
2 license, that on December 27, 2012, a First Amended Accusation was filed against him and
3 on December 31, 2013, a Decision was rendered wherein his license was revoked, with the
4 revocation stayed, and placed on five (5) years' probation with various standard terms and
5 conditions.

6 5. The current disciplinary action provides in pertinent part, "Following the
7 effective date of this Decision, if Respondent ceases practicing due to retirement, health
8 reasons, or is otherwise unable to satisfy the terms and conditions of probation, Respondent
9 may request voluntary surrender of Respondent's license." (Condition #15).

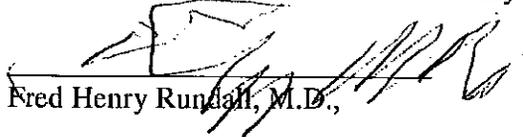
10 6. Upon acceptance of the Agreement by the Board, Respondent understands
11 he will no longer be permitted to practice as a physician and surgeon in California, and
12 also agrees to surrender his wallet certificate, wall license and D.E.A. Certificate(s).

13 7. Respondent hereby represents that he does not intend to seek relicensure or
14 reinstatement as a physician and surgeon. Respondent fully understands and agrees,
15 however, that if Respondent ever files an application for relicensure or reinstatement in the
16 State of California, the Board shall treat it as a Petition for Reinstatement of a revoked
17 license in effect at the time the Petition is filed. In addition, any Medical Board
18 Investigation Report(s), including all referenced documents and other exhibits, upon which
19 the Board is predicated, and any such Investigation Report(s), attachments, and other
20 exhibits, that may be generated subsequent to the filing of this Agreement for Surrender of
21 License, shall be admissible as direct evidence, and any time-based defenses, such as
22 laches or any applicable statute of limitations, shall be waived when the Board determines
23 whether to grant or deny the Petition.
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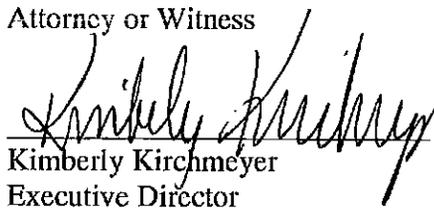
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ACCEPTANCE

I, Fred Henry Rundall, M.D., have carefully read the above Agreement and enter into it freely and voluntarily, with the optional advice of counsel, and with full knowledge of its force and effect, do hereby surrender Physician's and Surgeon's Certificate No. G50482, to the Medical Board of California for its acceptance. By signing this Agreement for Surrender of License, I recognize that upon its formal acceptance by the Board, I will lose all rights and privileges to practice as a Physician and Surgeon in the State of California and that I have delivered to the Board my wallet certificate and wall license.


Fred Henry Rundall, M.D.,

10-24-2016
Date

Attorney or Witness

Kimberly Kirchmeyer
Executive Director
Medical Board of California

Date
November 10, 2016
Date

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

In the Matter of the Accusation)
Against:)
)
)
FRED RUNDALL, M.D.)
)
Physician's and Surgeon's)
Certificate No. G 50482)
)
Respondent)
_____)

Case No. 17-2010-205130

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on December 31, 2013 .

IT IS SO ORDERED: December 2, 2013 .

MEDICAL BOARD OF CALIFORNIA



Dev GnanaDev, M.D., Chair
Panel B

1 KAMALA D. HARRIS
Attorney General of California
2 ROBERT MCKIM BELL
Supervising Deputy Attorney General
3 KLINT JAMES MCKAY
Deputy Attorney General
4 State Bar No. 120881
300 So. Spring Street, Suite 1702
5 Los Angeles, CA 90013
Telephone: (213) 576-1327
6 Facsimile: (213) 897-9395
E-mail: Klint.McKay@doj.ca.gov
7 *Attorneys for Complainant*

8 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
9 **DEPARTMENT OF CONSUMER AFFAIRS**
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 17-2010-205130

12 **FRED RUNDALL, M.D.**
13 **3941 Chevy Chase Drive**
La Canada Flintridge, CA 91011
14 **Physician's and Surgeon's Certificate No. G**
50482

OAH No. 2013020585
STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER

15 Respondent.

16
17 In the interest of a prompt and speedy settlement of this matter, consistent with the public
18 interest and the responsibility of the Medical Board of California of the Department of Consumer
19 Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order
20 which will be submitted to the Board for approval and adoption as the final disposition of the
21 Accusation.

22 PARTIES

23 1. Kimberly Kirchmeyer (Complainant) is the Interim Executive Officer of the Medical
24 Board of California. She brought this action solely in her official capacity and is represented in
25 this matter by Kamala D. Harris, Attorney General of the State of California, by Klint James
26 McKay, Deputy Attorney General.

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1 to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails
2 to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary
3 Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal
4 action between the parties, and the Board shall not be disqualified from further action by having
5 considered this matter.

6 12. The parties understand and agree that Portable Document Format (PDF) and facsimile
7 copies of this Stipulated Settlement and Disciplinary Order, including Portable Document Format
8 (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

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

12 **DISCIPLINARY ORDER**

13 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 50482 issued
14 to Respondent FRED RUNDALL, M.D. (Respondent) is revoked. However, the revocation is
15 stayed and Respondent is placed on probation for five (5) years on the following terms and
16 conditions.

17 1. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of resuming
18 the practice of medicine after successful completion of Clinical Training Program set forth in
19 Paragraph 3 below, Respondent shall enroll in a course in medical record keeping equivalent to
20 the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education
21 Program, University of California, San Diego School of Medicine (Program), approved in
22 advance by the Board or its designee

23 Respondent shall provide the program with any information and documents that the
24 Program may deem pertinent. Respondent shall participate in and successfully complete the
25 classroom component of the course not later than six (6) months after Respondent's initial
26 enrollment. Respondent shall successfully complete any other component of the course within
27 one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense
28 and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of

1 licensure.

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

7 Respondent shall submit a certification of successful completion to the Board or its
8 designee not later than 15 calendar days after successfully completing the course, or not later than
9 15 calendar days after the effective date of the Decision, whichever is later.

10 2. PROFESSIONALISM PROGRAM. Within 60 calendar days of resuming the
11 practice of medicine after successful completion of Clinical Training Program set forth in
12 Paragraph 3 below, Respondent shall enroll in a professionalism program, that meets the
13 requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall
14 participate in and successfully complete that program. Respondent shall provide any information
15 and documents that the program may deem pertinent. Respondent shall successfully complete the
16 classroom component of the program not later than six (6) months after Respondent's initial
17 enrollment, and the longitudinal component of the program not later than the time specified by
18 the program, but no later than one (1) year after attending the classroom component. The
19 professionalism program shall be at Respondent's expense and shall be in addition to the
20 Continuing Medical Education (CME) requirements for renewal of licensure.

21 A professionalism program taken after the acts that gave rise to the charges in the
22 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
23 or its designee, be accepted towards the fulfillment of this condition if the program would have
24 been approved by the Board or its designee had the program been taken after the effective date of
25 this Decision.

26 Respondent shall submit a certification of successful completion to the Board or its
27 designee not later than 15 calendar days after successfully completing the program or not later
28 than 15 calendar days after the effective date of the Decision, whichever is later.

1 3. CLINICAL TRAINING PROGRAM. Prior to practicing medicine, Respondent
2 shall enroll in and successfully complete a clinical training or educational program equivalent to
3 the Physician Assessment and Clinical Education Program (PACE) offered at the University of
4 California - San Diego School of Medicine ("Program"). Respondent shall successfully complete
5 the Program not later than six (6) months after Respondent's initial enrollment unless the Board
6 or its designee agrees in writing to an extension of that time.

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

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

20 At the completion of any additional educational or clinical training, Respondent shall
21 submit to and pass an examination. Determination as to whether Respondent successfully
22 completed the examination or successfully completed the program is solely within the program's
23 jurisdiction.

24 Respondent shall not practice medicine until Respondent has successfully completed the
25 Program and has been so notified by the Board or its designee in writing, except that Respondent
26 may practice in a clinical training program approved by the Board or its designee. Respondent's
27 practice of medicine shall be restricted only to that which is required by the approved training
28 program.

1 4. MONITORING - PRACTICE. Prior to resuming the practice of medicine,
2 Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s),
3 the name and qualifications of one or more licensed physicians and surgeons whose licenses are
4 valid and in good standing, and who are preferably American Board of Medical Specialties
5 (ABMS) certified. A monitor shall have no prior or current business or personal relationship with
6 Respondent, or other relationship that could reasonably be expected to compromise the ability of
7 the monitor to render fair and unbiased reports to the Board, including but not limited to any form
8 of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's
9 monitor. Respondent shall pay all monitoring costs.

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

17 Within 60 calendar days of the effective date of this Decision, and continuing throughout
18 probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall
19 make all records available for immediate inspection and copying on the premises by the monitor
20 at all times during business hours and shall retain the records for the entire term of probation.

21 If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective
22 date of this Decision, Respondent shall receive a notification from the Board or its designee to
23 cease the practice of medicine within three (3) calendar days after being so notified. Respondent
24 shall cease the practice of medicine until a monitor is approved to provide monitoring
25 responsibility.

26 The monitor(s) shall submit a quarterly written report to the Board or its designee which
27 includes an evaluation of Respondent's performance, indicating whether Respondent's practices
28 are within the standards of practice of medicine, and whether Respondent is practicing medicine

1 safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure
2 that the monitor submits the quarterly written reports to the Board or its designee within 10
3 calendar days after the end of the preceding quarter.

4 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of
5 such resignation or unavailability, submit to the Board or its designee, for prior approval, the
6 name and qualifications of a replacement monitor who will be assuming that responsibility within
7 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60
8 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a
9 notification from the Board or its designee to cease the practice of medicine within three (3)
10 calendar days after being so notified Respondent shall cease the practice of medicine until a
11 replacement monitor is approved and assumes monitoring responsibility.

12 5. FAILURE TO COMPLETE COURSEWORK Complainant acknowledges
13 Respondent's current inability to complete the coursework required by the terms herein due to his
14 present illness. Therefore, notwithstanding anything else in this document, Respondent's failure
15 to enroll in the courses set forth in Paragraphs 1, 2, and 3 shall not be considered a probation
16 violation, so long as he does not practice medicine. Prior to practicing medicine, he shall
17 successfully complete the Clinical Practice Program set forth in Paragraph 3, but may register for
18 and complete the coursework in Paragraphs 1 and 2 after such resumption. Respondent
19 acknowledges that in the event he does not resume the practice medicine within two years from
20 the effective date hereof, his medical license will be cancelled. However, he is not be required to
21 notify the Board of his nonpractice pursuant to Paragraph 12 hereunder, unless such nonpractice
22 occurs after Respondent's successful completion of the Clinical Practices Program set forth in
23 Paragraph 3 above.

24 6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the
25 Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the
26 Chief Executive Officer at every hospital where privileges or membership are extended to
27 Respondent, at any other facility where Respondent engages in the practice of medicine,
28 including all physician and locum tenens registries or other similar agencies, and to the Chief

1 Executive Officer at every insurance carrier which extends malpractice insurance coverage to
2 Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15
3 calendar days.

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

5 7. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent
6 is prohibited from supervising physician assistants.

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

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

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

15 10. GENERAL PROBATION REQUIREMENTS.

16 Compliance with Probation Unit

17 Respondent shall comply with the Board's probation unit and all terms and conditions of
18 this Decision.

19 Address Changes

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

25 Place of Practice

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

1 License Renewal

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

4 Travel or Residence Outside California

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

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

11 11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be
12 available in person upon request for interviews either at Respondent's place of business or at the
13 probation unit office, with or without prior notice throughout the term of probation.

14 12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board
15 or its designee in writing within 15 calendar days of any periods of non-practice lasting more than
16 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
17 defined as any period of time Respondent is not practicing medicine in California as defined in
18 Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month
19 in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All
20 time spent in an intensive training program which has been approved by the Board or its designee
21 shall not be considered non-practice. Practicing medicine in another state of the United States or
22 Federal jurisdiction while on probation with the medical licensing authority of that state or
23 jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall
24 not be considered as a period of non-practice.

25 In the event Respondent's period of non-practice while on probation exceeds 18 calendar
26 months, Respondent shall successfully complete a clinical training program that meets the criteria
27 of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and
28 Disciplinary Guidelines" prior to resuming the practice of medicine.

1 Respondent's period of non-practice while on probation shall not exceed two (2) years. If
2 this occurs, Respondent understands that his license will be cancelled. Such cancellation will be
3 procedural and not disciplinary.

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

5 Periods of non-practice will relieve Respondent of the responsibility to comply with the
6 probationary terms and conditions with the exception of this condition and the following terms
7 and conditions of probation: Obey All Laws; and General Probation Requirements.

8 13. COMPLETION OF PROBATION. Respondent shall comply with all financial
9 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the
10 completion of probation. Upon successful completion of probation, Respondent's certificate shall
11 be fully restored.

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

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

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ENDORSEMENT

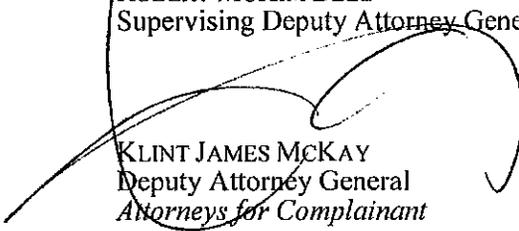
The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated:

9/5/13

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General



KLINT JAMES MCKAY
Deputy Attorney General
Attorneys for Complainant

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Stipulation 2.0.docx

Exhibit A

Accusation No. 17-2010-205130

1 JURISDICTION

2 3. This Accusation is brought before the Board under the authority of the following
3 laws. All section references are to the Business and Professions Code unless otherwise indicated.

4 STATUTORY PROVISIONS

5 4. Section 2227 of the Code states:

6 "(a) A licensee whose matter has been heard by an administrative law judge of the Medical
7 Quality Hearing¹ Panel as designated in Section 11371 of the Government Code, or whose default
8 has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary
9 action with the division, may, in accordance with the provisions of this chapter:

10 "(1) Have his or her license revoked upon order of the division.

11 "(2) Have his or her right to practice suspended for a period not to exceed one year upon
12 order of the division.

13 "(3) Be placed on probation and be required to pay the costs of probation monitoring upon
14 order of the division.

15 "(4) Be publicly reprimanded by the division.

16 "(5) Have any other action taken in relation to discipline as part of an order of probation, as
17 the division or an administrative law judge may deem proper.

18 "(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical
19 review or advisory conferences, professional competency examinations, continuing education
20 activities, and cost reimbursement associated therewith that are agreed to with the division and
21 successfully completed by the licensee, or other matters made confidential or privileged by
22 existing law, is deemed public, and shall be made available to the public by the board pursuant to
23 Section 803.1."

24 ///

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

1 5. Section 2228 of the Code provides:

2 "The authority of the board or the California Board of Podiatric Medicine to discipline a
3 licensee by placing him or her on probation includes, but is not limited to, the following:

4 "(a) Requiring the licensee to obtain additional professional training and to pass an
5 examination upon the completion of the training. The examination may be written or oral, or
6 both, and may be a practical or clinical examination, or both, at the option of the board or the
7 administrative law judge.

8 "(b) Requiring the licensee to submit to a complete diagnostic examination by one or
9 more physicians and surgeons appointed by the board. If an examination is ordered, the board
10 shall receive and consider any other report of a complete diagnostic examination given by one or
11 more physicians and surgeons of the licensee's choice.

12 "(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including
13 requiring notice to applicable patients that the licensee is unable to perform the indicated
14 treatment, where appropriate.

15 "(d) Providing the option of alternative community service in cases other than violations
16 relating to quality of care."

17 6. Code section 2234 provides:

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

21 "(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the
22 violation of, or conspiring to violate any provision of this chapter.

23 "(b) Gross negligence.

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

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

1 A. At the time she began treatment with Respondent, D.D. was a 45-year-old African -
2 American woman who suffered from depression, hypertension, and seizure disorder. She
3 admitted to abusing cocaine. She was seen at Respondent's downtown office regularly, on
4 average about every three months, from March 30, 2005 to January 5, 2009.

5 B. A lumbar spine x-ray was done on February 13, 2006. Significant findings included
6 a one centimeter focal density in the L2³ vertebral body towards the pedicle⁴. A neurology
7 consultation by one Dr. Choi on April 25, 2006 was documented.

8 C. Respondent employed multiple nurse practitioners (NPs) and physician assistants
9 (PAs) to help with evaluating patients and performing hospital rounds. The office progress notes
10 were invariably a preprinted form documenting individual visits. However, the written
11 descriptions were scant and largely illegible. Most signatures from the office progress notes were
12 different from Respondent's signature, indicating that Respondent's assistant(s) (instead of
13 Respondent) saw the patients. Almost none of the progress notes showed documentation of
14 physical examinations; the preprinted physical examination sections were usually left blank.

15 D. On the September 5, 2006 office visit, D.D. reported a 30-pound weight loss. No
16 physical examination was documented for this visit. The assessment included seizure disorder,
17 hypertension, psychiatric disorder, osteoarthritis and weight loss; however, there was no actual
18 statement describing the current status of each condition. Furthermore, no differential diagnosis
19 was made as to the cause of her significant weight loss.

20 E. During the next visit on November 6, 2006, no follow up note was made regarding
21 patient's weight loss.

22 F. Around mid 2006, multiple tumor markings and CT scan of the chest and abdomen
23 were ordered. There was no entry in the medical records indicating the result of these tests. In
24 addition, there were no comments on this reflected in any of the following progress notes.

25 ///

26 _____
27 ³ L2 means the second lumbar vertebra, starting from the top of the lumbar section of the
28 spine.

⁴ A pedicle is a bony section on each side of a vertebra

1 G. D.D. was admitted once to the L.A. Metropolitan Medical Center from September 7,
2 2006 to September 9, 2006. The initial history and physical examination documented the
3 admitting diagnosis of hypertension⁵, fatigue, shortness of breath, and hyponatremia⁶. Although
4 D.D. complained of subjective dyspnea⁷, her physical examination showed excellent oxygenation
5 and breath sounds were only described as "diminished." It appears that the history and physical
6 examination was performed by Respondent's assistant, as the statement "this case was discussed
7 in full with Dr. Frederick Rundall" was made at the end of the notes for that visit. Blood sodium
8 upon admission was 128, consistent with the diagnosis of hyponatremia.

9 H. Nonetheless, Respondent ordered a low salt diet and intravenous ½ normal saline
10 solution upon D.D.'s admission; these orders continued unchanged to the end of her
11 hospitalization. In addition, no follow up sodium level was ordered during this hospitalization.

12 I. The dictated history and physical examination done in the evening of September 8,
13 2006 indicated that D.D.'s blood pressure was 111/65, which was normal. The plan was to start
14 intravenous normal saline, although the main diagnosis was hypertension. A chest x-ray done on
15 September 8, 2006 was reported unremarkable by the radiologist, one Dr. Martin Schwartz.

16 J. An office progress note dated April 17, 2008 documented that D.D. was to be directly
17 admitted to "COA Hospital" for diarrhea and weakness. However, there is no follow up record on
18 whether that occurred or what happened there if it did.

19 K. Respondent's office progress notes lacked relevant history and physical findings as
20 evidenced by the fact that the physical examination portion of the preprinted progress notes were
21 left blank. Respondent did not document fully or adequately to justify patients' diagnosis or
22 treatment plan. D.D.'s hospital admission documented a diagnosis that did not match pertinent
23 treatment. The notes that exist appear to be random and are disorganized.

24 L. Respondent committed an extreme departure from the standard of care by failing
25 repeatedly to complete his own progress note/form regarding history and physical examination

26 _____
27 ⁵ Hypertension is high blood pressure

⁶ Hyponatremia is low blood sodium

⁷ Dyspnea means shortness of breath

1 findings. His hospital record keeping was not clear in term of diagnoses, plan of care and
2 justification for admissions.

3 9. Respondent committed an extreme departure from the standard of care in failing to
4 perform appropriate, if not full, evaluation and treatment on multiple occasions for D.D. as set
5 forth above. There were no specific findings (either by physical examinations or supportive
6 clinical tests) leading to an actual diagnosis. Appropriate tests were also frequently not ordered
7 for the purported diagnosis. Furthermore, apparent erroneous treatments were ordered,
8 specifically, ordering intravenous half normal saline fluid and low salt diet for D.D., who had
9 hyponatremia.

10 10. Respondent further committed an extreme departure from the standard of care in that
11 he exercised insufficient judgment before admitting D.D. to a hospital as an inpatient. Physicians
12 are required to establish justifiable reason(s) for admitting patients as an inpatient in any hospital,
13 and Respondent did not do that.

14 **SECOND CAUSE FOR DISCIPLINE**
15 **(Incompetence as to Patient D.D. – Failure to Diagnose and Treat)**

16 11. By reason of the facts set forth above in the First Cause for Discipline Respondent is
17 subject to discipline for incompetence pursuant to Business and Professions Code sections
18 2234(d).

19 **THIRD CAUSE FOR DISCIPLINE**
20 **(Repeated Negligent Acts as to Patient D.D. – Failure to Diagnose and Treat)**

21 12. A. By reason of the facts set forth above in the First Cause for Discipline
22 Respondent is subject to discipline for repeated negligent acts pursuant to Business and
23 Professions Code sections 2234(c).

24 B. Respondent failed to exercise judgment or supervision with respect to the
25 services rendered by his N.P.'s and P.A.'s. Although Respondent cosigned essentially all the
26 assistants' orders and health and physical histories, there was no documentation by Respondent
27 with respect to his meeting with the patient, if this ever occurred at all. Respondent did nothing
28

1 other than initial the health and physical or progress notes; this constitutes a failure of supervision
2 and review of the care given to D.D.

3 C. Respondent failed to refer D.D. to the appropriate specialists to address her
4 various ailments which were outside the scope of Respondent's expertise. These included but
5 were not limited to her depression and addiction issues.

6 **FOURTH CAUSE FOR DISCIPLINE**
7 **(Failure to Maintain Adequate and Accurate Records as to Patient D.D.)**

8 13. Respondent is subject to discipline for failure to maintain adequate and accurate
9 records relating to the provision of professional services under Business and Professions Code
10 sections 2266. The records he kept of his treatment of D.D. were inadequate and inaccurate, in
11 that they did not contain a regular recording of D.D.'s subjective complaints, Respondent's
12 observations, his assessment, and treatment plan.

13 **FIFTH CAUSE FOR DISCIPLINE**
14 **(Gross Negligence as to Patient E.D.⁸ – Failure to Diagnose and Treat)**

15 14. Respondent is subject to discipline pursuant to Code section 2234(b) (gross
16 negligence) as to Patient E.D. The facts and circumstances are as follows.

17 A. E.D. was a 55 years old African American man at the time he was first treated by
18 Respondent. Respondent treated E.D. from March 2006 to March 2012. He became a regular
19 patient of Respondent after his hospitalization in March 2006. Multiple records documented that
20 E.D. used crack cocaine.

21 B. Respondent employed multiple nurse practitioners (NPs) and physician assistants
22 (PAs) to help with evaluating patients and performing hospital rounds. The office progress notes
23 were invariably a pre-printed form documenting individual visits. However, the written
24 descriptions were scant and largely illegible. Furthermore, most providers' signatures were not
25 legible. Almost all of these signatures from the office progress notes were different from
26 Respondent's signature, suggesting that Respondent's assistant(s) (instead of Respondent) saw

27 ⁸ The names are abbreviated for privacy reasons.
28

1 the patients. Almost none of the progress note showed documentation of physical examinations;
2 the preprinted physical examination sections were usually left blank.

3 C. Office visits were frequent and almost monthly. Narcotic pain medications, including
4 Oxycodone, Vicodin and Tylenol with codeine, were prescribed regularly on a monthly basis.
5 The rationale for each visit was usually listed by the nursing staff as "meds refill." Referral
6 requests to pain clinic and orthopedics were made in December 2006, however there was no
7 documentation regarding the outcome of these.

8 D. There were four hospital admissions listed in the medical records from L.A.
9 Metropolitan Medical Center. All admissions were short stay hospitalizations. The first
10 admission was from March 13, 2006 to March 14, 2006. The admitting complaint was testicular
11 swelling, but the handwritten physical examination notes did not reveal fever or elaborate
12 significant genital findings. There was no leukocytosis or complete blood count. Cardiac enzymes
13 were ordered but no specific imaging study was ordered to evaluate patient's testicles.
14 Furthermore, no official diagnosis was listed regarding the testicular problem, and there was no
15 discharge summary in the medical record.

16 E. E.D.'s second admission was from May 23, 2006 to May 26, 2006. The patient was
17 admitted for chest pain, and the handwritten history and physical examination documented both
18 chest and back pain. The physical examination showed a blood pressure of 150/103 and 158/90.
19 Both cardiac and pulmonary examinations were unremarkable. The patient was admitted for
20 cardiac evaluation, but the subsequent cardiac evaluation was negative for cardiac illness.

21 F. On May 25, 2006, a consultation with cardiologist Dr. Windgrove Daniel was
22 obtained. Dr. Daniel commented that patient's chest pain was atypical. Since cardiac enzymes
23 were normal and an electrocardiogram⁹ showed only left ventricular hypertrophy¹⁰, he
24 recommended that the patient be discharged with a follow up outpatient cardiac stress test. The
25 discharge summary dictated by Respondent listed the following diagnoses: mitral valve disorder,
26

27 ⁹ An electrocardiogram is a heart scan.

28 ¹⁰ Hypertrophy is a type of swelling.

1 essential hypertension, cardiac dysrhythmia¹¹, lumbago¹², hyperlipidemia¹³, and an abnormal
2 electrocardiogram. However, there was no record regarding patient's cardiac stress test results or
3 the resolution of his other problems. It is noteworthy that the discharge summary contradicts Dr.
4 Daniel's opinion, in that he found no evidence of dysrhythmia, as set forth in the discharge
5 summary.

6 G. E.D.'s third hospital admission was from September 8, 2006 to September 9, 2006.
7 His admitting complaints included cough and dyspnea. In contrast, the nursing admitting note
8 documented E.D. complained of a productive cough but no shortness of breath. E.D. was
9 admitted for chronic obstructive pulmonary disease (COPD) exacerbation. A handwritten
10 physical examination revealed normal vital signs and indicated that his lung sound was "harsh."
11 Treatments with bronchodilators -- but no systemic corticosteroid or antibiotic -- were ordered.
12 A chest x ray was ordered but no report is in the medical record. There was no discharge
13 summary in the medical record.

14 H. E.D.'s fourth admission was from May 2, 2008 to May 5, 2008. A history and
15 physical record was dictated by one of Respondent's assistants, and Respondent authenticated it,
16 again without comment. E.D. was ultimately admitted for weakness and dehydration. His vital
17 signs at admission were normal and without orthostatic changes¹⁴. His BUN¹⁵ was 11 and
18 creatinine¹⁶ was 1.1.

19 I. The only significant intervention during this hospitalization was intravenous fluid
20 and oral Vicodin as needed. There was no radiographic study to work up possible renal disease
21 although one of the discharge diagnoses was renal stones. The dictated discharge summary listed
22 the following diagnoses: dehydration, calculus of kidney, malaise and fatigue, pure
23 hypercholesterolemia¹⁷, degeneration of intervertebral disk, osteoarthritis¹⁸, tobacco use disorder,

24 ¹¹ Dysrhythmia is an irregular heartbeat.

25 ¹² Lumbago is lower back pain.

26 ¹³ Hyperlipidemia is abnormally high lipid (fat molecule) levels in the blood.

27 ¹⁴ An orthostatic change refers to those which occur when a patient stands up.

28 ¹⁵ BUN means blood urea nitrogen and is a measure of renal function.

¹⁶ Creatinine levels are a measure of the kidneys' efficiency.

¹⁷ Hypercholesterolemia is the presence of high levels of cholesterol in the blood.

¹⁸ Osteoarthritis is a condition of chronic arthritis, without inflammation.

1 and mixed/unspecified drug abuse. No follow up, referral or treatment was done with respect to
2 any of these illnesses, however.

3 J. Respondent's office progress notes lacked relevant history and physical findings as
4 evidenced by the fact that the physical examination portion of the preprinted progress notes were
5 left blank. Respondent did not document anything that would fully or adequately justify the
6 patient's diagnosis or treatment plan. E.D.'s hospital admission notes did not match the
7 treatment. The notes that exist appear to be random and are disorganized.

8 K. Respondent committed an extreme departure from the standard of care by failing
9 repeatedly to complete his own progress note/form regarding history and physical examination
10 findings. His hospital record keeping was not clear in term of diagnoses, plan of care and
11 justification for admissions.

12 15. Respondent committed an extreme departure from the standard of care in failing to
13 perform appropriate evaluation and treatment of E.D. on multiple occasions as set forth above.
14 There were no specific findings (either by physical examination or supportive clinical tests)
15 leading to an actual diagnosis. Appropriate tests were not ordered to establish the purported
16 diagnosis.

17 16. Respondent further committed an extreme departure from the standard of care in that
18 he exercised insufficient judgment before admitting E.D. to a hospital. Physicians are required to
19 establish justifiable reason(s) for hospitalizing patients, and Respondent did not do that.

20 **SIXTH CAUSE FOR DISCIPLINE**
21 **(Incompetence as to Patient E.D. -- Failure to Diagnose and Treat)**

22 17. By reason of the facts set forth above in the Fifth Cause for Discipline Respondent is
23 subject to discipline for incompetence pursuant to Business and Professions Code sections
24 2234(d).

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2 **SEVENTH CAUSE FOR DISCIPLINE**
3 **(Repeated Negligent Acts as to Patient E.D. – Failure to Diagnose and Treat)**

4 18. A. By reason of the facts set forth above in the Fifth Cause for Discipline above,
5 Respondent is subject to discipline for repeated negligent acts pursuant to Business and
6 Professions Code sections 2234(c).

7 B. In addition, Respondent failed to exercise judgment or supervision with respect
8 to the services rendered by his NPs and P.A.'s. Although Respondent cosigned essentially all the
9 assistants' orders and health and physical histories, there was no documentation by Respondent
10 with respect to his meeting with the patient, if this ever occurred at all. Respondent did nothing
11 other than initial the health and physical or progress notes; this constitutes a failure of supervision
12 and review of the care given to E.D.

13 C. Respondent also failed to refer E.D. to the appropriate specialists to address his
14 various ailments which were outside the scope of Respondent's expertise. These included but
15 were not limited to his drug abuse issues.

16 **EIGHTH CAUSE FOR DISCIPLINE**
17 **(Failure to Maintain Adequate and Accurate Records as to Patient E.D.)**

18 19. Respondent is subject to discipline for failure to maintain adequate and accurate
19 records relating to the provision of professional services under Business and Professions Code
20 sections 2266. The records he kept of his treatment of E.D. were inadequate and inaccurate, in
21 that they did not contain a regular recording of the E.D.'s subjective complaints, Respondent's
22 objective observations, his assessment, and treatment plan.

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NINTH CAUSE FOR DISCIPLINE
(Gross Negligence as to Patient W.W.¹⁹ – Failure to Diagnose and Treat)

20. Respondent is subject to discipline pursuant to Business and Professions Code sections 2234(b) [gross negligence] as to Patient W.W. The facts and circumstances are as follows.

A. In July 2006, when Respondent first began seeing W.W., he was then a 58-year-old African-American man. He carried a diagnosis of chronic hepatitis C, COPD²⁰, depression, and muscle pain. W.W. admitted to cocaine use. He was eventually diagnosed with prostate cancer in July 2009.

B. From the records, it appears that Respondent employed multiple N.P.'s and P.A.'s to help with evaluating W.W. in the office and in performing hospital rounds, but rarely if ever treated or evaluated W.W. himself.

C. The office progress notes were preprinted forms, which purportedly documented individual patient visits. However, the written documentation was scant and largely illegible. Furthermore, most provider signatures were not legible. Most signatures from the office progress notes were different from Respondent's signature. This suggests that Respondent's assistant(s) and not Respondent saw the patient. Almost all of the progress notes showed no documentation of physical examinations, as the preprinted physical examination sections were usually blank.

D. Office visits were frequent and almost every month. Narcotic pain medication, Vicodin was prescribed regularly on a monthly basis. The reason for most visits, as stated by the nursing note, was "meds refill."

E. There were three hospital admissions to Los Angeles Metropolitan Medical Center reflected in the medical records. All admissions were short stay hospitalizations.

F. The first admission was from October 20, 2006 to October 22, 2006. It was a direct admission for COPD exacerbation. From the hand-written history and physical notes, W.W.'s

¹⁹ The names are abbreviated for privacy reasons.

²⁰ COPD means chronic obstructive pulmonary disorder.

1 lungs sound was harsh without documented wheezes. Vital signs were within normal limits. His
2 chest x-ray was normal. It is noteworthy that no oxygen, nebulized bronchodilator²¹, or systemic
3 corticosteroid²² was ordered, although this patient was apparently admitted for COPD
4 exacerbation. These would have been standard treatments for this malady, and therefore this
5 absence is unusual and indicates that no good faith effort was made to actually diagnose and/or
6 treat W.W.

7 G. W.W.'s discharge summary indeed listed shortness of breath and COPD as diagnoses,
8 but as noted, he received no treatment for this.

9 H. W.W.'s second admission was from March 31, 2008 to April 4, 2008 at City of
10 Angels Medical Center for leg cellulitis. The only record in the charts was the discharge
11 summary; again it did not appear that Respondent or his surrogates addressed W.W.'s complaints.

12 I. W.W.'s third admission was December 4, 2007, again for cellulitis; however, there
13 were no records of this admission (other than the fact that W.W. was hospitalized) in
14 Respondent's records.

15 21. Respondent committed an extreme departure from the standard of care in failing to
16 perform appropriate evaluation and treatment on multiple occasions for W.W. as set forth above.
17 There were no specific findings (either by physical examinations or supportive clinical tests)
18 leading to an actual diagnosis. Appropriate tests were frequently not ordered for the purported
19 diagnosis.

20 22. Respondent further committed an extreme departure from the standard of care in that
21 he exercised insufficient judgment before admitting W.W. to a hospital as an inpatient.
22 Physicians are required to establish justifiable reason(s) for admitting patients to as an inpatient in
23 any hospital, and Respondent did not do that.

24 ///

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26 _____
27 ²¹ A nebulized bronchodialator is a machine or drug which widens the bronchial tubes to
28 ease breathing.

²² A corticosteroid is a steroid which reduces inflammation.

1 **THIRTEENTH CAUSE FOR DISCIPLINE**
2 **(Gross Negligence as to Patient K.Y.²³ – Failure to Diagnose and Treat)**

3 26. Respondent is subject to discipline pursuant to Business and Professions Code
4 sections 2234(b) [gross negligence] as to Patient K.Y. The facts and circumstances are as
5 follows.

6 A. K.Y. was a 48-year-old man when he began to treat with Respondent in March of
7 2006; Respondent's medical records show only one office visit on March 26, 2006. K.Y.'s main
8 complaint was a urinating problem. Respondent's impressions were hypertension, adult well
9 exam, and urinary obstruction. The signature on the intake did not appear to belong to
10 Respondent.

11 B. There were seven hospitalizations at Los Angeles Metropolitan Medical Center listed
12 in the medical records. All admissions were for less than four days stay. Multiple records
13 confirmed that that K.Y. used crack cocaine.

14 C. K.Y.'s first admission was from January 27, 2006 to January 29, 2006. K.Y. was
15 admitted for shortness of breath and painful urination. In contrast, the admitting nurse
16 documented neck and back pain in addition to urination problem as K.Y.'s initial complaints. The
17 history and physical interview performed by James, one of Respondent's physician assistants,
18 revealed normal vital signs and wheezes in the lungs.

19 D. The nursing records during this first examination showed room air oxygen saturation
20 of 95%, and documented that K.Y. had a history of drug abuse. However, another history and
21 physical taken at that time reflected that K.Y. had no street drug habit. The admitting diagnoses
22 were acute bronchitis and "rule-out" urinary tract infection. A subsequent leukocyte count was
23 normal, but urinalysis was abnormal for many leukocytes. A nebulized bronchodilator, antibiotic,
24 and pain medication were ordered. There was no discharge summary in the medical record.

25 E. A second admission occurred between February 5, 2006 and February 6, 2006. K.Y.
26 was admitted directly from the Source Assessment Center, which had a business relationship with

27 ²³ The names are abbreviated for privacy reasons.

1 Respondent, for shortness of breath. The history and physical performed by one of Respondent's
2 physician assistants revealed normal vital signs and wheezing.

3 F. Nonetheless, the diagnoses were asthma exacerbation, schizophrenia and
4 hypertension. Nebulized bronchodilators were ordered. The patient appeared stable the next day
5 for discharge from the hospital.

6 G. The patient's third admission was from February 23, 2006 to February 27, 2006. K.Y.
7 was again admitted directly from the Source Assessment Center for cellulitis of his right foot.
8 The signature on the health and physical history is illegible. The admission orders were given by
9 one Dr. Fajardo.

10 H. Intravenous antibiotic and wound care were provided during this hospitalization.
11 Again, there is no discharge summary in the chart.

12 I. K.Y.'s fourth admission was from March 17, 2006 to March 19, 2006. He was
13 admitted for intermittent difficult urination. The history and physical was performed by one Dr.
14 Archana Chaudhary. According to the nursing records, the admitting orders were given over the
15 phone by D. Amos, a physician assistant. The admitting diagnoses were dysuria²⁴ and "rule out"
16 benign prostatic hypertrophy.

17 J. Laboratory results, including the leukocyte count, were within normal limits. No visit
18 was done by a physician or an assistant on March 18, 2006, as Dr. Chaudhary wrote, "Patient was
19 not available in the room to be seen by me." No hospital orders were written on March 18, 2006.
20 During this entire hospitalization, no intravenous fluids or medication were ordered.

21 K. K.Y. was subsequently discharged from the hospital on March 19, 2006. A discharge
22 summary dictated by Respondent stated the discharge diagnoses were neck pain, back pain,
23 shortness of breath, and dehydration.

24 L. K.Y.'s fifth admission was from September 6, 2006 to September 9, 2006. He was
25 admitted directly to the hospital for cough and fever. A history and physical examination dictated
26 by an unknown assistant of Respondent revealed a fever of 101.2. A lung examination showed

27 _____
28 ²⁴ Dysuria means painful or difficult urination.

1 diffused crackles. A chest radiograph demonstrated right and left perihilar²⁵ infiltrates. The
2 diagnosis was pneumonia. Nebulized bronchodilators and intravenous antibiotics were ordered. A
3 pulmonary consultation was done by Dr. Basharat. The discharge summary stated pneumonia as
4 the main diagnosis.

5 M. Respondent was not involved in K.Y.'s sixth and seventh hospital admissions.

6 27. Respondent committed an extreme departure from the standard of care in failing to
7 perform appropriate, if not full, evaluation and treatment on multiple occasions for K.Y. as set
8 forth above. There were no specific findings (either on physical examinations or supportive
9 clinical tests) leading to an actual diagnosis. Appropriate tests were frequently not ordered for the
10 presumed diagnosis.

11 28. Respondent further committed an extreme departure from the standard of care in that
12 he exercised insufficient judgment before admitting K.Y. to a hospital as an inpatient. Physicians
13 are required to establish justifiable reason(s) for admitting patients to as an inpatient in any
14 hospital, and Respondent did not do that.

15
16 **FOURTEENTH CAUSE FOR DISCIPLINE**
(Incompetence as to Patient K.Y. – Failure to Diagnose and Treat)

17 29. By reason of the facts set forth above in the Thirteenth Cause for Discipline
18 Respondent is subject to discipline for incompetence pursuant to Business and Professions Code
19 sections 2234(d).

20
21 **FIFTEENTH CAUSE FOR DISCIPLINE**
(Repeated Negligent Acts as to Patient K.Y. – Failure to Diagnose and Treat)

22 30. A. By reason of the facts set forth above in the Thirteenth Cause for Discipline
23 Respondent is subject to discipline for repeated negligent acts pursuant to Business and
24 Professions Code sections 2234(c).

25 B. Respondent failed to exercise judgment or supervision with respect to the
26 services rendered by his NPs and P.A.'s. Although Respondent cosigned essentially all the

27 _____
28 ²⁵ Perihilar means in the area of the depression in the lung where the heart is located

1 assistants' orders and health and physical histories, there was no documentation by Respondent
2 with respect to his meeting with the patient, if this ever occurred at all. Respondent did nothing
3 other than initial the health and physical or progress notes; this constitutes a failure of supervision
4 and review of the care given to K.Y.

5 C. Respondent failed to refer K.Y. to the appropriate specialists to address his
6 various ailments which were outside the scope of Respondent's expertise. These included but
7 were not limited to his drug abuse issues.

8
9 **SIXTEENTH CAUSE FOR DISCIPLINE**
(Failure to Maintain Adequate and Accurate Records as to Patient K.Y.)

10 31. Respondent is subject to discipline for failure to maintain adequate and accurate
11 records relating to the provision of professional services under Business and Professions Code
12 sections 2266. The records he kept of his treatment of K.Y. were inadequate and inaccurate, in
13 that they did not contain a regular recording of the K.Y.'s subjective complaints, Respondent's
14 objective observations, his assessment, and treatment plan.

15 **SEVENTEENTH CAUSE FOR DISCIPLINE**
16 **(Repeated Negligent Acts as to Patient M.M.)**

17 32. Respondent is subject to discipline pursuant to Business and Professions Code
18 sections 2234(c) [Repeated Negligent Acts] as to Patient M.M. The facts and circumstances are
19 as follows.

20 A. The standard of medical practice in California is to obtain previous
21 mammograms, order follow-up compression views, and/or obtain further radiologic consultation.
22 If the patient fails to proceed with the follow-up radiologic care there should be ample
23 documentation of this refusal by the patient in the patient's office chart.

24 B. M.M. had her initial mammographic abnormality found in January 2006.
25 Responsibility for follow-up radiologic evaluation and comparison to prior mammograms is
26 probably shared between the original imaging center and Respondent.

27 C. Respondent and/or members of his office staff attempted at least 5 times to
28 obtain follow-up breast imaging (March 2006, September 2006, August 2007, November 2007,

1 November 2008, and June 2009). Therefore, Respondent and his staff had knowledge of a breast
2 mammographic abnormality, but documentation of this abnormality, a follow-up plan for the
3 patient, and documentation of this discussion with the patient is not in Respondent's office notes.
4 This was a simple departure from the standard of care.

5 D. The standard of medical practice in California is to document a patient's
6 chemotherapy treatment each time it is administered. This documentation should include the
7 patient's name, vital signs, body surface area, drug and doses administered, date and
8 administration times.

9 E. Respondent's chemotherapy administration notes for cycle 1, days 1 and 2 are
10 essentially copies of each other for drugs, doses and administration times. Also, the notes for
11 these two chemotherapy days are unsigned. Furthermore, in one place, Respondent's notes state
12 that herceptin²⁶ was held after November 18, 2009, but on the chemotherapy administration sheet
13 for November 19, 2009, Respondent stated that herceptin was still being administered. Thus,
14 Respondent's chemotherapy administration notes for M.M. are confusing, contradictory at times,
15 and lack fundamental information about the chemotherapy actually administered on a given day.

16 33. The above constitute repeated acts of negligence pursuant to Code section 2234(c).

17 **EIGHTEENTH CAUSE FOR DISCIPLINE**
18 **(Incompetence as to Patient M.M.)**

19 34. Respondent is subject to discipline for incompetence pursuant to Business and
20 Professions Code sections 2234(d) [Incompetence]; the facts and circumstances are as follows.

21 A. The standard of medical practice in California is to use one of several standard
22 treatment protocols for the adjuvant treatment²⁷ of HER2+ breast cancer, the type M.M. had.
23 Treatment protocols for the adjuvant treatment of HER2+ breast cancer can include
24

25 ²⁶ Herceptin is a monoclonal antibody which interferes with the HER2/neu receptor. Its
26 main use is to treat certain breast cancers.

27 ²⁷ Adjuvant treatment means the use of a pharmacological or immunological agent that
28 modifies the effect of other agents, such as a drug or vaccine. They are often included in vaccines
to enhance the recipient's immune response to a supplied antigen, while keeping the injected
foreign material to a minimum.

1 herceptin/Cytosan/taxotere/herceptin/carboplatin/taxotere, and
2 Adriamycin/Cytosan/taxol/herceptin but are not strictly limited to these protocols. Respondent
3 chose to treat M.M. with Cytosan/methotrexate/fluorouracil/Herceptin (CMF/Herceptin) for
4 adjuvant chemotherapy. This is not a standard regimen for the adjuvant treatment of HER2+
5 breast cancer.

6 B. Therefore, the choice of this regimen and its rationale would need to be well
7 documented in the patient's chart before it was used. Furthermore, the method of administration
8 chosen by Respondent for CMF/Herceptin (8 hours per day, 5 days per week, and 2 weeks per
9 month) is not a standard adjuvant breast cancer chemotherapy protocol.

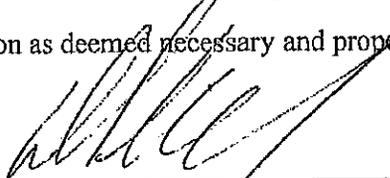
10 35. By reason of the facts set forth above, Respondent is subject to discipline for
11 incompetence pursuant to Business and Professions Code sections 2234(d).

12
13 **PRAYER**

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

- 16 1. Revoking or suspending Physician's & Surgeon's Certificate number G 50482, issued
17 to Frederick Rundall, M.D.;
- 18 2. Revoking, suspending, or denying approval of his authority to supervise physicians'
19 assistants, pursuant to Section 3527 of the Code;
- 20 3. Ordering him to pay the costs of probation monitoring, if placed on probation; and,
21 4. Taking such other and further action as deemed necessary and proper.

22
23 DATED: December 27, 2012


24 LINDA K. WHITNEY
25 Executive Director,
26 Medical Board of California,
27 Department of Consumer Affairs,
28 State of California,
Complainant

LA2012605111