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

In the Matter of the First Amended Accusation Against:	)	
Hanna Queen Rhee, M.D.	)	**Case No. 800-2015-018187**
Physician's and Surgeon's Certificate No. A 116932	)	
Respondent	)	

DECISION

The attached Proposed Decision 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 August 16, 2019.

IT IS SO ORDERED July 19, 2019.

MEDICAL BOARD OF CALIFORNIA

By: Kristina Lawson

Kristina D. Lawson, J.D., Chair
Panel B

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In the Matter of the First Amended Accusation Against:	Case No. 800-2015-018187
HANNA QUEEN RHEE, M.D.,	OAH No. 2018030315
Physician's and Surgeon's Certificate No. A 116932,	
Respondent.	

PROPOSED DECISION

Administrative Law Judge Tiffany L. King, Office of Administrative Hearings (OAH), State of California, heard this matter on May 13 through 17, 2019, in Sacramento, California.

Megan O'Carroll, Deputy Attorney General, appeared on behalf of complainant Kimberly Kirchmeyer (complainant), in her official capacity as Executive Director of the Medical Board of California (Board), Department of Consumer Affairs (Department).

Benjamin Fenton, Attorney at Law, represented Hanna Queen Rhee, M.D. (respondent), who was present.

Evidence was received, the record was closed, and the matter was submitted for decision on May 17, 2019.

FACTUAL FINDINGS

Procedural Background

1. On May 11, 2011, the Board issued Physician's and Surgeon's Certificate No. A 116932 (license) to respondent. The license is in full force and effect and will expire on August 31, 2020, unless revoked or renewed.

2. In October 2017, complainant filed a Petition for Interim Suspension Order with OAH, alleging that respondent was unable to practice medicine safely due to a mental health condition, and seeking to suspend respondent's license until an accusation was served and a decision rendered thereon. On November 9, 2017, an administrative law judge issued a Decision and Order (ISO Decision) denying the petition because complainant failed to prove that respondent had a mental illness.

3. On January 9, 2018, complainant, in her official capacity, filed and served an Accusation against respondent. Respondent timely filed a Notice of Defense and requested an administrative hearing. On November 16, 2018, complainant, in her official capacity, filed and served a First Amended Accusation against respondent. At hearing, complainant requested to amend the First Amended Accusation by striking the thirteenth and fourteenth causes of action (paragraphs 75 through 82.) Respondent did not object, and these causes of action and paragraphs were stricken.

4. The First Amended Accusation alleges that respondent is unable to practice her profession safely due to mental illness affecting competency. (Bus. & Prof. Code, § 822.) Specifically, complainant contends that respondent suffers persecutory delusional disorder affecting her ability to accurately interpret reality. The First Amended Accusation also alleges that respondent engaged in unprofessional conduct by committing gross negligence and repeated negligent acts with respect to eight patients in her care, and falsifying the medical records of one patient in her care. (Bus. & Prof. Code, § 2234 and 2261.)

Respondent's Professional Background

5. In 1996, respondent completed her Bachelor of Science in Biological Sciences at the University of California, Irvine (UC Irvine). The following year, 1997, she completed a Bachelor of Science in Biotechnology at the University of Southern Florida. In 2002, she completed her Medical Doctorate at the University of Southern Florida College of Medicine. Following medical school, respondent began a one-year residency program in pathology at the University of Colorado Health Sciences Center. She did not complete the program, and instead enrolled in a two-year residency program for psychiatry. Respondent completed her first year of the residency program, but was placed on probationary status on March 15, 2006, for "academic performance issues." Effective June 30, 2006, respondent resigned from the program "for personal reasons." Respondent is currently licensed to practice medicine in Hawaii (2006), California (2011), and Virginia (2012). She is not board-certified in any specialty.

Employment at Orchard Hospital Medical Specialty Center

6. On February 27, 2015, respondent began working as a locum tenens physician at Orchard Hospital Medical Specialty Center (Orchard Clinic), in Gridley, California. On the same date, respondent was issued a copy of Orchard Clinic's Medical Staff Bylaws, and

Rules and Regulations. On April 15, 2015, respondent signed a three-year Professional Services Agreement to work as a primary care physician at Orchard Hospital.

7. Kirsten Storne-Piazza has worked at Orchard Clinic for 25 years, and has served as the clinic administrator for the past six years. She is responsible for the overall operation of the clinic, including responding to inquiries and complaints by staff and patients. In 2015, Ms. Storne-Piazza handled complaints regarding physicians by informing the medical director, investigating the allegations, and referring the matter to medical staff for peer review, when necessary.

8. Ms. Storne-Piazza was unaware of any concerns regarding respondent's behavior or patient care while she was a locum tenens physician. However, soon after respondent was hired as a full-time physician, Ms. Storne-Piazza began to receive several complaints regarding respondent from other staff members, including:

a. During her tenure at Orchard Clinic, respondent would not shake hands with others out of fear of passing germs. She instead preferred to give an "elbow bump."

b. On one occasion, Ms. Storne-Piazza met with another locum tenens physician, Robert Winshall, M.D., in a closed office to discuss the doctor's concerns regarding respondent's patient care. Staff witnessed respondent standing outside of the office and "shushing" staff as they walked by, stating "I'm trying to listen to what they are saying."

c. On July 25, 2015, staff members witnessed respondent going through Dr. Winshall's desk, books and papers when Dr. Winshall was not present.

d. On August 3, 2015, staff members witnessed respondent going through the desk drawers of Dr. Delbert Beiler, and the belongings of Family Nurse Practitioner (FNP) Jordan Frazer, and FNP Betty LeBrun.

e. Henry Starkes, M.D., Medical Director for Orchard Clinic, had observed that respondent stored blankets, a bedroll, and clothing in her office. He also received reports from other staff that respondent was sleeping overnight in her office.

f. On several occasions, respondent was observed removing mail from other physicians' mailboxes.

9. Ms. Storne-Piazza also received several complaints from patients and staff that respondent did not touch or examine them when they presented for appointments. Other physicians complained that respondent failed to properly examine or treat new patients for serious medical conditions, instead making new appointments for these patients with other

practitioners. Ms. Storne-Piazza reported these complaints to Dr. Starkes, and referred the matters for peer review.[1]

10. Dr. Starkes has been the medical director for Orchard Clinic since at least 2015. In this position, he directs the medical duties of the physicians and other medical professionals at the clinic, performs evaluations of physicians and physician assistants, and is a member of the Medical Peer Review Committee. Dr. Starkes testified at hearing, noting that he also received several complaints from Dr. Winshall about respondent. Dr. Winshall complained that respondent was referring too many of her patients to him for follow-up visits. Dr. Starkes met with respondent and discussed the proper procedure for referring patients to another physician. Dr. Starkes noted it was difficult to talk with respondent because she typically accused him of yelling at her, even though he was using a normal tone and volume of voice. During one of their discussions, respondent informed Dr. Starkes that she would not physically examine male patients.

AUGUST 6, 2015 MEETING

11. Steven Stark has been the chief executive officer (CEO) for Orchard Hospital since January 1, 2015. His duties include overseeing the executive team, acting as a liaison between the hospital foundation and the auxiliary fundraising arms of the hospital, dealing with complaints about staff that cannot be handled at the department level, and reviewing patient complaints. On August 6, 2015, CEO Stark met with respondent to discuss concerns regarding her behavior. Dr. Starkes and Ms. Storm-Piazza were also present. When asked why she went through other physicians' desks, respondent stated she was looking for the physicians' notes regarding patients whom they examined. Respondent agreed that it was not appropriate to look through another doctor's desk unless it were an emergency, and there was no emergency present in these instances. Respondent was also advised that staff had observed her going through other physicians' mail in their mailboxes. Respondent explained she was trying to "help out" by going through the mail and personally delivering it to the provider. She was directed to stop going through other's mail and to leave the mail in the mailboxes for the provider or his/her staff.

Next, respondent admitted to listening through a closed door behind which a confidential meeting was taking place between Dr. Starkes and Dr. Winshall. Respondent explained she wanted to make sure that nothing false was being said about her, and that she had, in fact, heard false statements about her. CEO Stark advised respondent that her behavior was inappropriate and violated the parties' expectations of privacy when discussing a personnel matter.

Finally, respondent was asked about accessing patient records for patients who were not hers, in violation of HIPAA.[2] CEO Stark presented respondent with a list of patient

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[1] These peer review matters are discussed in the Standard of Care section, *infra*.

[2] Health Insurance Portability and Accountability Act of 1996.

names whose records respondent had accessed and for whom the HIPAA Officer could not find evidence that respondent had treated them. Respondent stated she would communicate her reasons for accessing those records at a later date.

CEO Stark handed respondent a Formal Written Warning outlining respondent's behaviors and setting forth a proposed action plan. The action plan stated, "[respondent] will cease this behavior immediately or be subject to immediate termination as outlined in [her contract]." It further recommended respondent meet with Dr. Starkes regarding building better relationships with her coworkers, noting that her behavior "is breaking down trust with staff at all levels in the clinic." Respondent indicated she did not receive a copy of her contract and did know what sections of her contract she had breached with her behavior. CEO Stark printed out a copy of the signed contract and gave it to respondent. Respondent then indicated she still had personal belongings in Dr. Udom's desk, which was her previous desk. CEO Stark instructed respondent to have a witness present with her when she collected her belongings from the desk.

AUGUST 7, 2015 INCIDENT

12. On August 7, 2015, CEO Stark visited Orchard Clinic to follow-up on an employee matter. Upon his arrival, a nursing assistant asked CEO Stark to respond to an active dispute between respondent and Dr. Winshall. CEO Stark entered the physicians' shared office where respondent was standing and Dr. Winshall was sitting; CEO Stark closed the door. Dr. Winshall was upset that respondent was going through Dr. Udom's desk, noting that respondent had previously gone through his desk without permission as well. Respondent, in a raised voice, stated that she had received patient complaints that Dr. Winshall had performed exams with sexual overtones and slammed his charts down in exam rooms. As Dr. Winshall denied the allegations, respondent began going through Dr. Udom's desk again. CEO Stark reminded respondent that if she needed to retrieve personal items from her previous desk, she should bring a witness. When asked, respondent confirmed she understood CEO Stark's expectation going forward regarding going through another provider's desk.

Following the meeting, respondent confronted CEO Stark in the hallway and accused CEO Stark of "attacking" her. CEO Stark denied attacking respondent "in any way," and noted that respondent had confronted him. CEO Stark spoke in a normal tone and volume of voice; he did not raise his voice at respondent. Respondent often accused others of "yelling at" or "attacking" her, even though eyewitnesses said the addressee spoke in a normal tone and volume of voice.

13. A few hours later, CEO Stark provided respondent with a blank incident report form. He advised her that inappropriate sexual conduct during patient exams was a serious offense, and asked that she document her allegations against Dr. Winshall on the form. Respondent agreed. In a memorandum dated August 25, 2015, CEO Stark advised respondent that he had not received an incident report form from her, and reminded her of

her obligations under the mandatory reporting statutes. The record did not reflect whether respondent ever turned in an incident report form as directed.

AUGUST 29, 2015 INCIDENT

14. In mid-August 2015, Dr. Starkes instructed respondent not to be at the clinic on weekends she was not scheduled to work. Respondent was not scheduled to work on August 29, 2015. On that date, Dr. Winshall was scheduled to be at the clinic at 10:00 a.m. to complete his charting so those visits could be billed.

15. At 8:41 a.m., Ms. Storne-Piazza received the following text message from respondent: "Hi. Fyi. Someone key'd [*sic*] Karen [Heustis] car on the 21st. We think it was Winshall. I hope she is not in any danger." At 8:49 a.m., Karen Heustis, M.D., called Ms. Storne-Piazza stating that she was afraid to be in the same building as Dr. Winshall because he had keyed her car.[3] Ms. Storne-Piazza stated she would direct Dr. Winshall to complete his charts in the medical records room.

16. At 10:38 a.m., respondent texted the following to Ms. Storne-Piazza: "Fyi. Winshall is walking thru clinic in halls giving us threatening glares. We shut our doors in hiding." Ms. Storne-Piazza called the clinic and staff informed her that respondent was "causing problems." Ms. Storne-Piazza next called respondent, reminded her that she was not supposed to be at the clinic when not scheduled to work, and directed her to go home. Respondent replied that she would stay in her office and do work. Ms. Storne-Piazza again directed her to leave, and respondent agreed. Thereafter, staff observed respondent "shuffling through" items on Dr. Winshall's desk. When asked what she was doing, respondent replied "just checking" things.

17. At 10:58 a.m., a nurse at the clinic sent the following text message to Ms. Storne-Piazza: "stop by. Shit was started and you're [*sic*] presence would be appreciated. Dr. Rhee is still here." Ms. Storne-Piazza immediately went to the clinic to confirm respondent was still there. Upon her arrival, she saw Dr. Winshall in his assigned area completing charts. Ms. Storne-Piazza walked to respondent's office. She tried to open the door, but something was blocking it. Respondent stated "that's my barricade." When asked why she had not left as instructed, respondent stated she had decided to stay to "protect Karen." Ms. Storne-Piazza again instructed respondent to leave, and respondent complied.

18. Following the August 29, 2015 incident, Ms. Storne-Piazza referred the matter for peer review, citing respondent's "inappropriate" and "hostile behavior" towards another provider.

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[3] At hearing, Ms. Storne-Piazza recalled that Dr. Heustis's vehicle had been keyed "at some point," but that no one had filed a complaint accusing a physician of doing it. There was no evidence that any staff member was responsible for the damage to the vehicle.

PRELIMINARY SUSPENSION

19. By memorandum dated September 3, 2015, CEO Stark informed respondent that, based on the recommendation provided by the Medical Peer Review Committee, her privileges at Orchard Clinic had been placed on a preliminary suspension, and that a Medical Peer Review Committee's investigation would be presented to the Executive Committee the following week. Later that evening, respondent sent a text message to Ms. Storne-Piazza stating her intent to resign. In a written letter dated September 4, 2015, respondent formally gave two-weeks' notice of her resignation. On September 8, 2015, CEO Stark advised respondent that Orchard Clinic accepted respondent's resignation, effective September 17, 2015. Respondent was not to report to work during this two-week period. In a handwritten letter to CEO Stark, dated September 8, 2015, respondent stated:

> On behalf of my patients, I would like to express my deep disappointment in your comments and actions which have compromised patient care in our hard working rural community. It is unfortunate you have chosen this patient population since they lack the resources to defend themselves against the hospital CEO who prevented them from access to quality medical care.

20. On November 2, 2015, Orchard Clinic prepared and filed a Health Facility/Peer Review Reporting Form (805 Complaint) with the Board, asserting that respondent had resigned during a peer review investigation regarding provider and patient complaints about her patient care. By letter dated November 10, 2015, CEO Stark advised respondent of the clinic's mandatory reporting requirements and provided a copy of the 805 Complaint filed with the Board.

Board Investigation

21. On November 17, 2015, the Board received the 805 Complaint filed by Orchard Clinic. The Board reviewed the 805 Complaint, opened an investigation, and assigned the case to Investigator Roberto Moya, who testified at hearing. Investigator Moya subpoenaed documents from Orchard Clinic to determine the basis for the peer review investigation of respondent. Orchard Clinic fully complied with the Board subpoena. Investigator Moya reviewed the documents and determined the Orchard Clinic investigation began as a result of a number of patient and staff complaints about respondent's behavior and clinical competence. Investigator Moya also interviewed several staff members.

22. Investigator Moya met with respondent at her private practice on March 30, 2016. Respondent stated she was running a primary care clinic and also provided house calls. Respondent asserted her resignation from the Orchard Clinic was spurred, in part, by her interaction with Dr. Starkes. Respondent believed Dr. Starkes "had something against [her]," and interfered with her patients, including changing patient treatment plans. Respondent was aware of an anonymous complaint against her that she did not perform

genital exams. However, she had informed the locum tenens company, Mede-Star, that she did not perform genital exams.

23. On January 3, 2017, Investigator Moya conducted an investigative interview of respondent. Respondent appeared at the interview without legal representation. Respondent asserted her work situation at Orchard Clinic became hostile when she learned about the peer review investigation. She tendered her resignation and opened a new private practice located not far from Orchard Clinic. Other relevant portions of respondent's investigatory interview regarding patient care are discussed in the Standard of Care section, *infra*.

Incompetence Based on Mental Illness – Nathan Lavid, M.D., Expert Witness

24. Complainant called Nathan Lavid, M.D., to testify as an expert witness. Dr. Lavid completed his bachelor of art in microbiology in 1993, and his medical degree in 1997, at the University of Kansas, in Lawrence. Following medical school, he completed a one-year internship in the department of neurology, pediatrics, psychiatry, and human behavior, and a three-year residency in the department of psychiatry and human behavior at the University of California, Irvine. Dr. Lavid next completed a one-year fellowship in the department of psychiatry at the University of Southern California, in Los Angeles. He was licensed to practice in California in 1998, and is board-certified by the American Board of Psychiatry and Neurology. Currently, Dr. Lavid is working in private practice and conducting clinical and forensic psychiatry as a psychiatric consultant for the New Found Life rehabilitation facility in Long Beach. He has also served as expert reviewer for the Board since 2007. Dr. Lavid has published in journals and books and presented on multiple psychiatric topics.

25. On August 18, 2017, Dr. Lavid conducted a psychiatric examination of respondent under Business and Professions Code section 820.[4] The evaluation included a three-hour interview and administration of the following diagnostic tests: Minnesota Multiphasic Personality Inventory, Second Edition (MMPI-2), Beck's Depression Inventory, and Beck's Anxiety Inventory. During the interview, Dr. David took a detailed personal history of respondent's upbringing, education, and medical career, including her interactions with staff and patients at Orchard Clinic. Regarding the latter, respondent confirmed her belief that Dr. Starkes had "something against [her]" and that someone had filed an anonymous complaint against her for not performing genital exams. Respondent also told Dr. Lavid that, following her resignation, she filed a complaint with the Office of the Inspector General (OIG), U.S. Department of Health and Human Services, wherein she alleged Orchard Clinic was a "pill mill." She asserted the hospital was currently under investigation and that there might be "some

[4] Business and Professions Code section 820 provides in pertinent part: "Whenever it appears that any person holding a license, certificate or permit under this division or under any initiative act referred to in this division may be unable to practice his or her profession safely because the licentiate's ability to practice is impaired due to mental illness, or physical illness affecting competency, the licensing agency may order the licentiate to be examined by one or more physicians and surgeons or psychologists designated by the agency."

influence" on the hospital and its employees to "say detrimental things about her to make her less credible." She also alleged the Board may have been similarly manipulated in bringing its action against her.

26. Respondent denied having symptoms of Obsessive-Compulsive Disorder (OCD), or having any compulsions related to fear of contamination. She stated she is less apt to shake hands because she does not want to be a conduit for spreading illness. Respondent denied symptoms of mania, such as grandiosity, and stated she is religious because "it gives [her] direction to tolerate and understand others." She denied being paranoid, but expressed being worried that Orchard Clinic and the Board had taken action against her because she had been a whistleblower. When Dr. Lavid asked respondent to explain the timeline discrepancies, she stated she did not feel comfortable discussing it. Other than her concerns about retaliation by the Board and Orchard Clinic continuing to operate as a "pill mill," respondent denied any other conspiracies. She also denied being harassed, followed, or spied upon.

27. On August 25, 2017, Dr. Lavid issued a report, opining that respondent has no diagnosable mental disorder under the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) and scored within normal limits on all diagnostic tests, but "[respondent] presently suffers from paranoia which could substantially impair her ability to safely practice medicine." Dr. Lavid explained his conclusions, as follows:

> Dr. Rhee was evaluated for an extensive period of time (over 3 hours) and during this time, she was able to focus and concentrate and her thought processes were linear and logical. She did not appear to be responding to internal psychotic processes. Also, she did not have any type of delusional-type thinking that is found in individuals with a delusional disorder, such as grandiosity, jealousy, somatic delusions, or bizarre delusions that are clearly implausible and/or not understandable. However, her thoughts regarding the Medical Board and the hospital could be construed as paranoia, which is found in individuals who suffer from persecutory type of delusional disorder.
>
> [¶] . . . [¶]
>
> Dr. Rhee does not exhibit, and denies, most types of thoughts and behaviors outlined in the persecutory type of delusional disorder. As such, she would not meet diagnostic criteria. However, she does have some thoughts that could be construed as paranoia, which would fit within the persecutory type of delusional disorder.
>
> [¶] . . . [¶]
>
> While it is difficult to make a definitive determination if her paranoia is of the severity to be delusional, I would rather defer on

the conservative side in light of her being a physician and having to make decisions that have a high degree of consequences if interfered by her delusional thinking. Paranoia affects a person's ability to interpret reality correctly, which might affect her ability to practice medicine safely, especially the fact that her thoughts are directed toward medical institutions, the facility and the . . . Board. Therefore, I would recommend that she receive psychiatric treatment and this should allow her to practice medicine safely. [¶] . . . [¶] Also, she needs to have a physical exam and stop being her own primary care physician to make sure that some of her paranoid thinking isn't the result of a physical condition and medically clear her for the use of psychotropic medication, if needed.

28. Thereafter, the Board requested asked Dr. Lavid to assume, hypothetically, that the facts alleged in the Accusation concerning respondent's behavior at Orchard were true; and if those assumed facts would alter Dr. Lavid's opinion as to whether respondent fit within the diagnostic criteria for persecutory delusional disorder. Specifically, Dr. Lavid was asked to assume the following as true:

a. On multiple occasions, Dr. Rhee perceived coworkers to be yelling or intimidating her although other present observed all to be speaking in normal voices;

b. Dr. Rhee was observed listening at doors and going through coworkers' offices and mailboxes due to concerns that these individuals possessed negative information about her;

c. Dr. Rhee is not a whistleblower for the Drug Enforcement Agency or the OIG;

d. Dr. Rhee barricaded herself in a room at the clinic due to feeling unsafe from another coworker, although that coworker was charting in a separate area of the facility and presented no threat to her; and,

e. Despite being employed as a primary care physician, Dr. Rhee declined to touch or examine patients when they presented for appointments, due to concerns regarding germs and/or religious objections.

29. In an addendum, dated October 23, 2018, Dr. Lavid opined:

Assuming these facts to be true, Dr. Rhee was not sincere in her responses to the interview and diagnostic tools I employed during

my evaluation. Assuming these facts to be true, Dr. Rhee is likely suffering from paranoid delusional disorder. Because such a disorder revolves medical setting and medical institutions, it would impair her ability to safely practice medicine.

30. At hearing, Dr. Lavid noted that respondent's case was "more difficult than most," and confirmed his opinion that respondent presently has a mental condition under the DSM-V, delusional disorder, which affects her ability to practice medicine safely. Dr. Lavid explained that delusional disorder is having delusions which are fixed on false beliefs. Often, these delusions can have a rationale or explanation; however, the temporal relationship does not make sense. Respondent presented with persecutory type delusions based on paranoia and respondent's belief that she is being maliciously aligned. During the three-hour interview, respondent complained that Orchard Clinic and the Board began retaliating against her because she had filed a complaint that Orchard Clinic was a "pill mill." However, her timeline did not match up. Issues first arose at the clinic in the summer of 2015 and the 805 Complaint was filed in September of that year. Respondent filed the "pill mill" allegations later. When Dr. Lavid asked respondent about her allegations and the timeline inconsistencies, respondent did not want to discuss it because Dr. Lavid's report would ultimately be released to the Board. Dr. Lavid found this response odd as most individuals who feel wronged want to be heard. However, when viewed in context with respondent's other behaviors, respondent's reaction was consistent with delusional disorder.

31. Dr. Lavid explained that doctors who have delusional disorder – persecutory type can present a risk or danger to patients. Physicians must deal with reality, and misperceptions about the world may influence respondent's decision-making from a medical standpoint.

32. Following Dr. Lavid's evaluation, respondent filed a complaint against him, alleging that he provided substandard care and that he demonstrated racial and religious intolerance in his evaluation.

Patient Care – Reinhardt G. Hilzinger, M.D., Expert Witness

33. Reinhardt G. Hilzinger, M.D., testified as an expert witness for the Board. He is board-certified in family medicine. Dr. Hilzinger graduated from the Medical College of Wisconsin, and did his residency in Family Practice at St. Luke's Hospital, Medical College of Wisconsin. He has been licensed to practice medicine in California since November 1989. Between 1988 and 1991, Dr. Hilzinger worked as a Staff Physician, Department of Family Medicine at the United States Air Force Hospital, Mather Air Force Base, in Sacramento. He then worked in family practice through the Sutter Medical Group in Sacramento for 25 years until he retired in 2016. Presently, Dr. Hilzinger works part-time as an orthopedic surgical assistant. Dr. Hilzinger's professional affiliations include membership in the American Academy of Family Practice, California Academy of Family Practice, Sacramento-Sierra Valley Medical Society and the National Tactical Officers Association. He has served as a Tactical Physician for the Sacramento County Sheriff Department Special Enforcement Detail.

In connection with this case, Dr. Hilzinger reviewed the Board's draft investigative report, the 805 Complaint, peer review and clinic records from Orchard Clinic for eight patients treated by respondent, the transcript of respondent's Board interview, and a CD recording of the interview. Dr. Hilzinger prepared a report, dated May 31, 2017, regarding the applicable standards of care and his findings regarding respondent's patient care. He testified at hearing consistent with his report.

PATIENT W.L.

34. Patient W.L. was a 53-year-old male who presented to respondent as a new patient seeking to establish care on March 16, 2015. His medical history included: coronary artery disease; heart attack (August 2014); multi-organ failure requiring dialysis; Crohn's Disease; Barrett's esophagitis; a coccyx decubitus; and, pneumonia. He had been recently treated in the emergency room (ER) for pneumonia. Patient W.L. was taking several medications which respondent documented in his electronic medical record (EMR).

Under review of symptoms, respondent charted that patient W.L. denied having chills, fatigue, fever, headache, lightheadedness, night sweats, sleep disturbance, or weight gain. Respondent's charting did not reflect any respiratory complaints or a review of symptoms for depression, anxiety, or attention deficit disorder (ADD). Under general examination, respondent charted that patient W.L. was "well-developed, well-nourished," with a stage 3 pressure ulcer of the coccyx with 2x2cm, and charted the rest as normal.

Respondent noted the following assessment and plan: (1) cardiac arrest – refer to cardiology; (2) ADD – no refill of medication until old records are obtained; psych referral; (3) depressive disorder – continue Trazodone; (4) anxiety state, unspecified – continue Clonazepam; (5) pressure ulcer, lower back – referral to wound care and nutrition for cachexia; (6) asthma, unspecified – continue ProAir inhaler; and (7) pneumonia – continue Azithromycin.

35. Patient W.L. next saw respondent for a follow-up appointment on March 27, 2015. In her charting, respondent described the patient as cachexic and "amphetamine'd [*sic*] cardiac arrest," with multiple myocardial infarctions, chronic pain rule out opiate dependence, and a recent ER visit for ventricular tachycardia (Vtach). Respondent charted the review of symptoms and examination as all being normal, again listing the patient as well-developed and well-nourished. The heart exam listed "no murmurs, regular rate and rhythm." The neck exam listed a normal range of motion. At the end of the exam, respondent charted that the patient was cachexic and had a decreased range of motion in his lower back with no elicited pain. No further explanation was given.

Respondent charted the following assessment and plan: (1) cardiac arrest, unspecified cardiac dysrhythmia – refer to cardiology, see primary care physician for slow methylphenidate taper off, refer to radiology; (2) ADD, anxiety, and depression – refill methylphenidate, refer to psychiatry; (3) Gastroesophageal reflux disease (GERD) – remain

on Nexium; (4) chronic pain due to trauma – spinal survey ordered, refill Oxycodone, refer to pain management; and, (5) cachexia – refer to nutritionist.

36. Respondent next saw patient W.L. on April 17, 2015, to review his echocardiogram and spinal x-ray results. Patient W.L. also complained that: his left arm was going numb; he had decreased sensation in both hands; he had burned his right hand on the stove and could not move it well; his left hand had a burning pain like frostbite with no explanation. Respondent charted that patient W.L. needed to taper off the amphetamines. She charted the review of systems and general examination as normal, including that the patient was well-developed and well-nourished, and the neck had normal range of motion. No back examination was documented. No neurological exam was documented, except: the right upper extremity was "less sensory" decreased grip, and normal range of motion 2+ pulses; left hand was less sensory normal motor, normal range of motion 2+ pulses.

Respondent assessed patient W.L. as having chronic pain and trauma. She ordered an MRI of the brain with and without contrast, an MRI cervical thoracic and lumbar spine with and without contrast. Under notes, respondent charted, "2/2 pressure sore abscess pain post-cardiac arrest rehab bedrest. PLAN: cont[inue]transition to methadone: start methadone 10mg bid stop oxycontin." Respondent also assessed unspecified neuralgia, neuritis, and radiculitis. Finally, she assessed cellulitis and abscess of unspecified site. She ordered serum uric acid, Vitamin-D hydroxy, testosterone, free and total, lipid panel, basic metabolic panel, and a CBC. Under notes, respondent wrote "It's worse than I thought." She documented a plan for fasting labs, decline taper, and an MRI monitor. Patient W.L. was given an injection of Rocephin. The results of the echocardiogram and spinal x-ray were not listed.

37. Patient W.L. passed away a couple of days later. Respondent did not fill out the death certificate because she needed instruction how to do so.

PATIENT D.B.

38. On May 11, 2015, patient D.B., 58 years old, presented to respondent with shortness of breath and having diarrhea for one week. Her past medical history included type 2 diabetes, anxiety, heart attack, neuropathy of the arms and legs, depression, chronic obstructive pulmonary disease (COPD), high cholesterol, hypertension, chronic pain, and allergy to outside air. Under review of systems, respondent did not chart anything regarding shortness of breath or diarrhea. Under examination, respondent charted: "GAIT ANALYSIS: SOB at rest, 'I don't want to go to the ER . . . I wont [*sic*] go to the ER,' high bp asymp, stable, ao x3 nad."

39. Respondent charted the following assessment and plan: other unspecified angina pectoris – start nitroglycerin .4mg sublingually; diarrhea – start Kaopectate; congestive heart failure – start the Imdur previously prescribed, and sublingual nitroglycerin; and, nausea alone – Phenergan injection, likely cardiac related. Respondent further noted that patient D.B. should follow up in two to three days. In her investigative interview,

respondent explained that she did not conduct a physical examination because the patient needed to go to the ER.

PATIENT J.B.

40. Patient J.B. was a 50-year-old man who saw respondent on July 5, 2015. Patient J.B. presented with a history of genital pain for three days. Respondent charted the patient's complaint as right scrotal pain, with no prior event, that came on suddenly. He had a pain level of 4 out of 10, and denied chest pain, dizziness, lightheadedness, stomach upset, dysuria, fever or chills, or nausea. Under the review of systems, respondent charted no positive findings. Under examination, respondent templated a list of examinations with normal findings for general, cardiac, lungs, and abdominal systems. She also noted, "genital: no rash, hernia, unable to elicit pain."

Respondent did not perform any genital examination on patient J.B. She did not order any cultures, urinalysis, or scrotal ultrasound. Respondent assessed patient J.B. as having "unspecified disorder of male genital organs," prescribed Motrin, and directed him to follow up with his primary care physician. Three days later, patient J.B. was examined by a different physician at the clinic and reported that his testicle was very painful during his appointment with respondent. The other physician noted that respondent did not order a urine test or check for chlamydia or gonorrhea.

41. In her investigative interview, respondent stated that she does not perform genital exams. Later, however, she asserted that she had palpated patient J.B.'s testicle and could not elicit pain.

PATIENT C.T.

42. On September 1, 2015, patient C.T. saw respondent for a hospital follow-up. The patient had been in the ER four days earlier after drinking on her birthday. She reported not feeling well and being shaky. Blood work from the ER showed she had low magnesium and sodium. Respondent charted the review of systems as normal. Under examination, respondent templated that the patient was in no acute distress, and was well-developed and well-nourished, her lungs were clear bilaterally, and her heart had regular rate and rhythm and no murmurs. No abdominal examination was charted. Respondent also charted the patient had bilateral conjunctival injection, boggy and grey nasal turbinates, wheezy breath, and resting fine motor tremor both hands. The patient appeared anxious, but denied suicidal ideation or possession of guns. The CAGE (problem drinking screen) was negative.

43. Respondent charted the following assessment and plans: (1) allergy – prescribe Albuterol inhaler and Claritin; (2) long-term use of medications – order labs for uric acid, hemoglobin A1c, magnesium, lipid panel, thyroid test, basic metabolic panel, complete blood count (CBC), erythrocyte sedimentation rate (ESR), liver function test, urine micro albumin, and a C-reactive protein (CRP); (3) elevated blood pressure – low salt diet

and monitoring; and, (4) alcohol withdrawal – start Klonopin. Respondent also assessed Patient C.T. as having anxiety, unspecified, but included no corresponding treatment plan.

44. On September 2, 2015, patient C.T.'s brother asked to speak with respondent about the prescription for Klonopin. Respondent would not discuss patient C.T. with him, and asked him to put his concerns in writing. In a written note to respondent, the brother stated that patient C.T. had detoxed in the ER one month earlier with a blood alcohol level of .72 percent, was suicidal and had been placed on involuntary mental health holds four times, and had recently texted him a suicide note. The brother was concerned about Klonopin, given the contraindications of alcohol use and suicidal ideation. He further reported that patient C.T. had been non-complaint with medications by not taking them, and that her blood pressure was 215/260 in the ER due to alcohol consumption.

45. During her investigative interview, respondent stated that she did not have access to the hospital records for patient C.T. that showed her history of depression and suicide attempts.

PATIENT G.C.

46. Patient G.C. was a 66-year-old male who saw respondent for anxiety and to establish new care on September 2, 2015. He also requested a refill for Ativan for anxiety and Nasonex for his allergies. Respondent charted that patient G.C. was an alcoholic, but had quit drinking one month earlier. He was seen by a cardiologist for an enlarged heart six months earlier. He also reported experiencing shortness of breath and an inability to walk more than five feet without getting winded. Respondent charted his prior medical history as COPD, an enlarged heart, and seizures. At the visit, he had a blood pressure of 180/121 and heart rate of 122. Under examination, respondent charted the patient: was alert with no acute stress; his heart was irregular with no murmurs, gallops or rubs; his lungs had decreased respiration in the bilateral lower lobes and rapid shallow wheezing throughout. Respondent further charted the administration of 0.2mg clonidine, and the patient's statement, "No, I won't go to the ER . . . I don't want to go . . . ok . . . I'll go to the ER . . . but I can't walk there because I can't breathe."

47. Respondent charted the following assessment and plan: (1) long-term medication use – order battery of labs abs for uric acid, hemoglobin A1c, lipid panel and cholesterol, thyroid test, basic metabolic panel, CBC, liver function test, and B-type natriuretic peptide; (2) hypertrophy of the prostate and lower urinary tract symptoms – no plan listed; (3) chronic airway obstruction – refer to ER and pulmonary diseases; (4) unspecified essential hypertension – refer to ER and prescribe Clonidine; and (5) atrial fibrillation – defer to ER.

48. Respondent called the ER physician and advised she was sending patient G.C. for treatment of tachycardia and hypertension. Patient G.C. arrived to the ER by wheelchair. His blood pressure was 140/101 and his heart rate was 104. His oxygen saturation was 98 percent and he had mild shortness of breath. Patient G.C. reported he had quit drinking and

marijuana one month earlier. He asked respondent to refill his Ativan because he was experiencing "severe anxiety to the point of blacking out." Respondent had refused to refill the prescription because she did not believe in that medication. The ER physician prescribed a one-week refill of Ativan and made a follow-up appointment for the next week. At his follow-up appointment, a different Orchard Clinic doctor prescribed Valium to patient G.C. to aid with his withdrawal symptoms and Revia to curb his alcohol cravings. The doctor also discussed addiction issues with patient G.C. and ordered imaging for his other medical conditions.

49. During her investigative interview, respondent denied that she authored the note in patient G.C.'s medical record because she could not "lock" her notes or follow up with results, even though her colleagues could.

PATIENT M.B.

50. On August 2, 2015, patient M.B., a 26-year-old female, presented to respondent with dizziness over the past week. Respondent charted the patient had dizziness, heard liquid in her ears, and was diagnosed with vertigo by a previous physician. She took Claritin nasal spray as a treatment; she had also been prescribed meclizine but it made her dizzy. Patient M.B. stated her two sisters had vertigo, she had an EKG a few months earlier, and her period was light. Respondent charted the patient was well-developed, well-nourished, and in no acute distress. The review of systems was templated as normal. There was no documented examination of the neck, ears, or eyes. Respondent charted the patient had bradycardia with a heart rate of 58.

51. Respondent documented the following assessment and plan: (1) long-term medication use – order labs for Vitamin B12 and Vitamin D, lipid panel, thyroid test, basic metabolic panel, CBC, liver function test, and pregnancy test; (2) unspecified peripheral vertigo and cardiac dysrhythmia – holter monitor ordered, prescribed promethazine and antihistamine; and (3) potential pregnancy – pregnancy test ordered. Respondent advised patient M.B. to follow up in one week.

52. Patient M.B. next saw respondent on August 7, 2015. Respondent reviewed the thyroid test results which showed a TSH level of 1.86, and a free T4 value of 71. Respondent diagnosed patient M.B. with hypothyroidism, prescribed levothyroxine. Respondent did not physically touch or examine patient M.B. during either the August 2nd or August 7th visit.

53. On August 9, 2015, patient M.B. presented to another physician with a rapid heart rate, change of mood after taking new medications, swollen throat, and poor appetite. The other physician stopped the levothyroxine and ordered repeat thyroid function tests.

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PATIENT J.G.

54. Patient J.G., a 76-year-old female, saw respondent on July 28, 2015. She presented with burning with urination, though she was unable to provide a urine sample during the visit. Patient J.G. also complained of tendonitis of the left shoulder and lower back. Respondent charted the following 10-point assessment: (1) nonspecific abnormal results of kidney function – results not charted, but referred to renal monitor; (2) diabetes type 2 – not discussed during visit, but ordered to continue medications and schedule yearly eye and foot exam; (3) coronary artery disease – not mentioned in chart notes; (4) malignant neoplasm of the breast – not discussed in chart; (5) malignant neoplasm of the middle lobe of lung – not discussed in chart; (6) malignant neoplasm of the lower lobe of lung – not discussed in chart; (7) unspecified ulcerative colitis – not discussed in chart, but referred to gastroenterology; (8) long term use of other medications – not discussed in chart; (9) unspecified polyarthropathy – not examined nor discussed in chart; and (10) dysuria – ordered to take urine cup home and return with sample.

55. Respondent also ordered a battery of labs for uric acid, hemoglobin A1c, Vitamin D, micro albumin, lipid panel, thyroid test, basic metabolic panel, CBC, ESR, liver function test, and CRP. Respondent did not chart any physical examination of patient J.G. She signed the EMR electronically on August 3, 2015.

56. On August 3, 2015, patient J.G. submitted a note to Orchard Clinic in which she stated that respondent did not physically examine her during the visit. Patient J.G. requested to be assigned to a different physician. On September 2, 2015, respondent added an addendum to patient J.G.'s EMR, which stated: "notified of EHR charting error. CORRECTION: gen a n o xo3 and cardio RRR no MGR lung unremark sans Rt M.L. psych pleasant coop."

57. In her investigative interview, respondent asserted that patient J.G. had tested positive for cocaine yet was prescribed high doses of narcotics from Dr. Starks. Nothing in patient J.G.'s EMR indicate she has tested positive for cocaine.

PATIENT M.L.

58. Patient M.L. was a 54-year-old male who fell down in the parking lot outside the Orchard Clinic on August 7, 2015. Melissa Chapman, a medical assistant at Orchard Clinic, was the first person to respond to the scene. Patient M.L. was sitting on the sidewalk with his back against the building, and appeared to be breathing normally. His wife stood next to him. When asked if he was ok, patient M.L stated he was a "little dizzy." His wife then explained that they had been referred to the clinic because patient M.L.'s blood pressure was low.

59. A nurse arrived at the scene with a wheelchair and oxygen. She helped patient M.L. into the wheelchair and started the oxygen. A minute or two later, respondent arrived at the scene and identified herself to the patient as a doctor. Respondent did not ask patient

M.L. or his wife any preliminary questions; patient M.L. did not complain of any chest pain, but he was pale and sweaty. Respondent did not touch or otherwise physically examine him. Respondent administered a nitroglycerin tablet to the patient and instructed him to place it under his tongue. Patient M.L. was then transported to the ER in a wheelchair.

60. At the ER, patient M.L.'s blood pressure was taken and was 74/34. It was determined that patient M.L had bacterial pneumonia and dehydration. He was given antibiotics and stayed in the hospital overnight for observation. On August 11, 2015, patient M.L. was seen by Dr. Beiler at the Orchard Clinic for a follow-up. No exam was documented. The assessment included: neck pain; diabetes type 2 uncontrolled; and unspecified essential hypertension.

61. In her investigatory interview, respondent denied that the patient's blood pressure was "that low," and that she gave him nitroglycerine because he appeared to be having a cardiac event based on his appearance and physical examination. The clinic medication logs show that, of the 24 times nitroglycerin was administered between May 2015 and August 25, 2015, 21 of the doses were ordered by respondent. At the interview, respondent accused Dr. Beiler of over-prescribing narcotics and alleged there was a drug ring in Butte County between Orchard Clinic and the Sheriff's Department.

STANDARD OF CARE

62. Dr. Hilzinger defined the standard of care as "the use of skill, knowledge, and care at arriving at a diagnosis and providing care for a patient that a reasonable doctor would use in the same or similar circumstances." He defined an extreme departure from the standard of care as "the absence or want of care, or doing something a reasonable doctor would not do in similar circumstances." Finally, he defined a simple departure from the standard of care as "not using reasonable skill, knowledge, and care in providing patient care."

Lack of Documentation

63. Dr. Hilzinger testified the standard of care requires documentation of patient visits to be clearly written or typed in the medical record in either the SOAP or similar format. SOAP stands for Subjective (what patient states), Objective (what the doctor observes), Assessment (doctor's findings), and Plan (doctor's plan for treatment). The note should contain the presenting complaint history, pertinent review of systems, pertinent past medical history, allergies, current medications, pertinent family and social histories. The examination should be complete with special focus on those body parts and organ systems that correlate with the chief complaint. Finally, the assessment and plan should correlate with the items discussed in the history and those items examined.

64. Dr. Hilzinger noted that, in her documentation, respondent often included items in her assessment which were never discussed in the patient history or examined during the exam. He further noted that most of respondent's notes under the general examination

and review of systems sections were auto-populated or templated and contradictory on multiple occasions. Finally, Dr. Hilzinger opined that in each of the below instances, respondent's documentation of patient visits constitutes an extreme departure from the standard of care.

65. Patient W.L.: Respondent described patient W.L. as well-developed and well-nourished when the patient was in fact cachectic. Respondent did not document any respiratory symptoms even though patient W.L. was recently treated for pneumonia. Despite the patient's history of coronary artery disease, respondent did not document anything concerning shortness of breath with activity, chest pain with activity, or leg swelling. She documented a history of ADD, anxiety and depression, but there was no documented review of ADD, anxiety or depression symptoms. Respondent also failed to document a methylphenidate taper.

On the April 17, 2015 chart, respondent did not chart a reason for transitioning the patient to methadone, or why she diagnosed him with cellulitis and abscess of unspecified site. Her neurological exam and use of the term "less sensory" to describe the sensory exam were inadequate. Respondent did not document the results of the echocardiogram or spinal xray. Finally, she did not document a reason for the Rocephin injection.

66. Patient D.B.: Respondent failed to document a physical exam the patient. In her interview with the Board investigator, respondent explained she did not perform an exam because the patient needed to go to the ER.

67. Patient J.B.: Respondent documented "unable to elicit pain," even though the patient reported a very painful testicle.

68. Patient J.G.: Respondent did not document an examination of the patient. Nine of the ten assessments listed by respondent were not included in the general examination or discussed in the history.

69. Patient M.B.: Despite presenting with dizziness and a history of vertigo, respondent did not document an exam of the neck, ears, or eyes for nystagmus or a gait exam.

70. Patient M.L.: Respondent failed to take a patient history or perform an exam. She did not document the visit at all.

71. Patient C.T.: Respondent documented an exam of the patient which was templated and inaccurate. She charted the patient as well-developed and well-nourished, despite the patient having a distended abdomen from malnutrition. Respondent did not take a detailed medical history offered by the patient's brother.

72. Patient G.C.: Respondent's documentation of the exam was inadequate. Respondent charted that the patient had decreased respirations, irregular heart rate, and

refused to go to the ER, but also described him as being in "no acute distress." Respondent also assessed the patient as having hypertrophy of the prostate but she did not examine the prostate nor discuss any urinary symptoms.

Inappropriate Ordering of Lab and Imaging Studies

73. Dr. Hilzinger testified the standard of care requires that laboratory orders and imaging studies should be based on the history and physical exam findings, and subsequent differential diagnoses. He noted that, on multiple patients, respondent templated that she ordered lab results for an assessment of "encounter for long-term current use of other medications." Dr. Hilzinger opined that each of the following actions by respondent constitutes an extreme departure from the standard of care.

74. Patient C.T.: Respondent ordered uric acid, hemoglobin A1c, magnesium, lipid panel, thyroid test, basic metabolic panel, CBC, ESR, liver function test, urine micro albumin, and a CRP. Dr. Hilzinger opined the ESR, CRP, urine micro albumin, A1c, thyroid panel, and uric acid labs were unnecessary. Rather, respondent should have ordered: (1) a folate level, which is necessary for alcoholics due to their poor nutrition; and (2) a prothrombin test to give a better indication of liver function in an alcoholic.

75. Patient G.C.: Respondent ordered a BNP, which Dr. Hilzinger explained is useful to evaluate congestive heart failure but not COPD. Dr. Hilzinger also opined there was no reason to order a thyroid function test, liver function test, lipid panel, and A1c.

76. Patient J.G.: Respondent ordered a full panel of lab tests which were not supported by the documented patient history or examination.

77. Patient M.B.: Respondent ordered a Vitamin B-12 level, a Vitamin D level, lipid panel, liver function test, and thyroid function tests, none of which are indicated for dizziness and a past history of vertigo. Dr. Hilzinger further opined that respondent ordered inappropriate thyroid tests and misdiagnosed the patient as hypothyroid.

78. Patient W.L.: Dr. Hilzinger found that none of the labs ordered by respondent were indicated. Respondent asserted she ordered the MRI because the patient had a stage 3 coccyx ulcer / abscess and had complained of a headache, stiff neck, and concentration problems. However, earlier in the note, respondent charted the patient had a normal range of motion in her neck. Under history, respondent did not mention a headache, stiff neck, or concentration issues. Respondent's assessment and subsequent imaging orders were not supported by the patient history and general examination.

Work-up for Scrotal Pain

79. The standard of care for treating scrotal pain includes: a urinalysis for chlamydia and gonorrhea, if sexually active; history of trauma or sports injury; genital exam

with attention to testicle size, tenderness, epididymis tenderness and position; hernia exam and urgent scrotal Doppler ultrasound if torsion is suspected.

80. Patient J.B.: Respondent did not order any cultures, urinalysis, or ultrasound. She documented a non-tender exam when the patient reported a painful scrotum. Respondent did not test the most likely cause of his pain – epididymitis. Dr. Hilzinger rejected respondent's explanation that she did not know how to perform a genital exam, noting that one cannot pass clinical rotations in medical school without proficiency in genital exams. Dr. Hilzinger opined that respondent's failures constitute an extreme departure from the standard of care.

Treatment for Suspected Hypothyroidism

81. Dr. Hilzinger stated the standard of care requires the treatment for suspected hypothyroidism to be based on the patient's symptoms, exam findings, and lab tests.

82. Patient M.B.: Respondent diagnosed the patient with hypothyroidism based on her low heart rate. However, there was no history of weight gain, hot or cold intolerance, skin or hair changes, menstrual changes, neck swelling, swallowing discomfort, or fatigue. Respondent did not perform or document a neck exam. Rather, her diagnosis and subsequent treatment were based on a minimally decreased T4 result with a normal TSH. Respondent inappropriately gave the patient a thyroid supplement; rather, she should have observed the patient for symptoms and repeated the thyroid studies in two to three months. Dr. Hilzinger opined that respondent's failures were an extreme departure from the standard of care.

Treatment for Alcohol Withdrawal

83. Dr. Hilzinger explained the standard of care requires the treatment for alcohol withdrawal to employ the use of benzodiazepines, such as Librium or Valium plus Thiamine, a multivitamin, with a folate supplement and beta blocker for blood pressure and tachycardia control. Treatment may also require inpatient care and observation.

84. Patient C.T.: Respondent prescribed the patient Klonopin, a benzodiazepine. However, Klonopin is not used for alcohol withdrawal and is contraindicated for use in patients with suicidal ideation. Respondent failed to prescribe Thiamine or multivitamin supplementation. Additionally, the patient presented with symptoms of severe alcoholism, which required an inpatient detoxification. Dr. Hilzinger opined that respondent's actions were an extreme departure from the standard of care.

Falsification of Medical Records

85. Dr. Hilzinger explained that when a mistake is made in the medical record, the standard of care requires the record be corrected as soon as possible with an addendum documenting the correction.

86. Patient J.G.: Respondent made an addendum to the patient's medical record on September 2, 2015, more than a month after the patient's visit on July 28, 2015. In the addendum, respondent documented an examination that never took place. Dr. Hilzinger opined that this was an extreme departure from the standard of care.

Administration of Sublingual Nitroglycerin

87. Dr. Hilzinger explained the standard of care requires the administration of sublingual nitroglycerin be based on a patient's history of substernal chest pain with neck, jaw, or left arm radiation, sweating, shortness of breath with activity, and known history of coronary artery disease.

88. Patient M.L.: Respondent did not obtain a patient history that met these requirements. The patient denied having chest pain in the ER. Respondent asserted she knew by his appearance and exam alone that he was having a cardiac event. However, respondent did not conduct an examination on the patient.

89. Dr. Hilzinger explained that nitroglycerin should not be given to a patient who has low blood pressure because it can lower the blood pressure drop even more, possibly causing organ failure or death. Further, it is only appropriate to use nitroglycerin in this situation if the physician is certain the patient is experiencing a heart attack. If there are no signs of a heart attack, it is inappropriate to administer nitroglycerin. Dr. Hilzinger examined the clinic's medication log between May 2015 and August 25, 2015. He noted that, of the 24 times that nitroglycerin was administered during this period, 21 of the doses were administered on respondent's orders.

90. Dr. Hilzinger opined that respondent's use of nitroglycerin constituted an extreme departure from the standard of care.

Respondent's Testimony and Evidence

91. Respondent is 49 years old. She was born in Chicago where her father was a physician and her mother a homemaker until she started working later in life as her husband's office manager. Respondent has an older brother, 50 years old, and an older sister, 51 years old.

92. Respondent grew up in a religious household. Her grandparents had co-founded the Young Nak Christian Church in North Korea in the 1920s. In the United States, respondent's parents attended the Presbyterian Church.

93. When respondent was in elementary school, her family moved to North Dakota and later Tampa, Florida. In Florida, respondent's family remained very religious and gravitated to the Southern Baptist Church. Respondent attended and graduated from a private Catholic high school in 1987. After high school, respondent moved to Orange County and lived with her aunt and uncle. She earned money by waitressing and eventually enrolled in Orange Coast College. Eventually, respondent transferred to UC Irvine as a part-time student and

continued to support herself with waitressing. Respondent explained that she learned the importance of frugality from her family and the Korean community.

94. Respondent did well in school and did not experience any type of emotional distress or other problems. After graduation, she moved to Hawaii and decided she wanted to pursue a medical degree. Respondent moved back to Florida, enrolled at the University of South Florida to obtain a second bachelor's degree, and applied to and was accepted to the University of South Florida College of Medicine. When respondent's father died in 1999, respondent took a leave of absence from medical school to mourn. After graduating medical school, respondent did not immediately pursue a residency or internship. Instead, in 2002, she moved to southern California and accepted a research position studying pain in mice at the University of California, San Diego (UC San Diego).

95. Eventually, respondent applied for and was accepted into a residency program at the University of Colorado, Denver. Respondent spent one year in the pathology residency program, but she left the program because she had an unknown reaction to the chemicals used in autopsies. Respondent transferred to the psychiatry residency program, the first year of which was an internal medicine internship, and the second year was clinical. Respondent did not complete the second year of residency, explaining that the clinical psychiatric exams performed by the residents did not incorporate the belief systems of their subjects.

96. Respondent moved back to Hawaii and obtained her medical license. She worked at a clinic and had her own private practice until 2011. At that time, she returned to California and became licensed in that state. She began her own private practice in San Diego, California, specializing in Lyme Disease. During this time, respondent lived in her car which she parked legally at the beach, and showered at the gym before going to work.

97. In 2011, to supplement her income, respondent contracted with MedXM to perform in-home health assessments throughout the country. She saved enough money to buy a home in southern California. However, respondent began to notice that MedXM would "up code" her time, which she believed to be medical fraud. She reported the suspected fraud to several government agencies. In her complaint, respondent also asserted that the EMR used by MedXM was too difficult to template and she could not use the computer system effectively. Ultimately, respondent was terminated from MedXM. Thereafter, she obtained a restraining order against MedXM's general counsel, based on allegations that he was threatening and harassing her.

98. In 2011, respondent also volunteered at the free family medicine clinic at UC San Diego. Respondent initially asserted she was appointed a faculty member of the clinic in 2012. She later clarified that she was not listed on any roster of faculty appointments for the school.

99. In early 2015, respondent began working for the locum tenens company, Medestar. She informed May Uzman at Medestar that she did not perform genital or breast exams due to her religious beliefs. She assumed Medestar would communicate her restrictions

to any hospital who contracted with her. At hearing, respondent explained that there are several verses in the Old Testament concerning nudity and shame. Based on her scripture studies, as well as her Catholic school instruction, respondent believes that putting a nude patient in a vulnerable position was akin to taking advantage of someone who was at a disadvantage. She also believes that her own nudity, e.g., running around naked, is an immoral act against God.

EMPLOYMENT AT ORCHARD CLINIC

100. When respondent first started as a locum tenens physician at Orchard Clinic, the clinic arranged for her to live in a cabin located on a property owned by a hospital employee. Prior to starting, respondent met Ms. Storne-Piazza who asked her if she had any restrictions. Respondent told her that she did not perform genital or breast exams, and Ms. Storne-Piazza said that was fine. Later, respondent made the same disclosure to Dr. Starkes who also raised no objection.

101. Regarding her practice of "elbow bumping," respondent explained that in 2013 and 2014, she read medical journal articles concerning drug resistant germs and inadequate handwashing. The articles contended that handshaking was doing more harm than good by spreading germs to other patients. Respondent began greeting patients and colleagues with an elbow bump in lieu of a handshake. She did not see anything inappropriate with the practice. Respondent also explained that handshaking is not common in Korean culture, where the custom is to bow politely when greeting each other.

102. Respondent explained that she checked the mailboxes for other physicians because she was trying to be nice, build bridges, and make friends with her colleagues. She denied taking mail addressed to another and not delivering it.

103. When respondent first started at Orchard Clinic, she shared an office with other physicians, including Drs. Winshall, Beiler, and Udom. She explained that when CEO Stark came to the clinic to speak with a physician, he often met the physician in the shared office and closed the door. Respondent denied listening in on conversations behind closed doors to see if something negative was being said about her. Instead, she was listening to see when she could enter the room. Respondent denied accusing CEO Stark of yelling at her in the hallway outside of the shared office.

104. Regarding Dr. Winshall's complaints against her, respondent explained that Dr. Winshall had been diagnosed with bipolar disorder, for which he was placed on a 10-year probation by the Board. As a result, Dr. Winshall often misconstrued respondent's statements and actions. Respondent always wanted someone else with her when she had to speak with Dr. Winshall, to act as a witness and confirm what she had said. Respondent admitted she was at times fearful of Dr. Winshall. Regarding the August 29, 2015 incident, she asserted that Dr. Winshall was walking up and down the hallways giving respondent and others threatening glares, so respondent went into her office and shut the door. However, she denied barricading the door.

105. When she met with CEO Stark, Dr. Starkes, and Ms. Storne-Piazza on August 6, 2015, respondent felt she was at a disadvantage. She had not yet received a copy of the clinic's bylaws or code of conduct, despite repeated requests. Respondent denied feeling persecuted by Orchard Clinic.

PATIENT CARE AND MAINTAINING ACCURATE RECORDS

106. When respondent started at Orchard Clinic, the clinic utilized an EMR software program called eClinical Works. Respondent had never used the program before. When she first started to use it, she found it to be "quite complicated," noting that there were a lot of pop-ups on the screen for labs and other messages. Once respondent electronically signed a note, it was "locked" and could no longer be altered. If she needed to make a change, respondent had to add an addendum. Before the note was locked, however, any physician could edit the note without doing an addendum.

107. Respondent admitted she made several errors in charting her notes. She explained that there were several templates on the EMR and she did not know how to delete information from the template when it not accurate. She conceded she should have deleted the "well-developed, well-nourished" templated note from patient W.L.'s EMR prior to electronically signing the note. Respondent also admitted to not documenting everything that she examined during a patient visit. However, other than documentation, respondent denied that she provided improper care for the eight patients identified in the First Amended Accusation.

108. After her resignation, respondent purchased an office building and opened her own private practice in Gridley. Currently, she continues to perform health assessments for Medicare and Medicaid patients.

OTHER MATTERS

109. At hearing, respondent asserted that the actions of Orchard Clinic and the Board's allegations against her were influenced, in part, by religious and cultural bias, including the testimonies of Drs. Lavid and Hilzinger. Respondent is a follower of Rick Warren and the Saddleback Church, and strives to follow a purpose-driven life. When something adverse happens to respondent, she believes it is a blessing because it leads her to prayer, meditation, and scripture, which in turn brings her closer to God. Respondent did not point to any specific incident or action which demonstrated bias on the part of anyone representing Orchard Clinic, the Board, or the expert witnesses, with respect to the matters at issue in this case.

110. After the Board's petition for an interim suspension order was denied, respondent wanted "to be part of the solution." She co-founded Black Patients Matter, a grassroots movement whose mission is to close the health care racial disparity for unemployed minorities. Presently, she spends several hours a month with Black Patients Matter and is in charge of its Facebook page.

111. Respondent has filed a federal civil right complaint against the Board, the Deputy Attorney General, Dr. Lavid, and others with respect to the allegations in the First Amended Accusation. At hearing, respondent expressed that she did not file the complaint out of anger, but because she wanted to "be part of the solution."

112. In January 2019, respondent took a physician prescribing course and medical recordkeeping course from UC San Diego School of Medicine. She found both courses helpful. In February 2019, she also took an anger management for healthcare professionals course. She decided to take the course because she was concerned with her cursing while driving in southern California traffic, and wanted to develop coping skills for her anger.

113. Donna Orr testified at hearing on respondent's behalf. Ms. Orr was respondent's patient in 2015 and 2016, and they developed a friendship over time. Ms. Orr described respondent as giving and generous, an "angel" and someone who is "incredibly honest to a fault." She related a recent incident where respondent came to her aid. Ms. Orr and her family lived in Paradise when the Camp Fire broke out. Ms. Orr was in southern California at the time. Respondent called her to see if she was safe and had a place to stay. Respondent then offered to let Ms. Orr and her family stay at her office, take whatever items she needed, and donate the rest to the fire victims. Respondent also gave Ms. Orr $1,000. Ms. Orr and her family lost everything in the fire. They moved into respondent's office while they looked for other housing.

114. Ms. Orr does not believe respondent is a paranoid person. Rather, she is always giving of herself, as well as open, loving and caring. Respondent never complained to Ms. Orr that she was being persecuted. Ms. Orr explained that respondent views everything as a blessing and a life lesson.

115. Respondent also submitted two letters of support from Dr. Margaret Juarez, M.D., and Randal Pham, M.D., signed under penalty of perjury, and dated May 8 and 9, 2019, respectively. These character references were admitted as administrative hearsay and have been considered to the extent permitted under Government Code section 11513, subdivision (d).[5]

Dr. Juarez has known respondent for two years, professionally and socially. She has served as the Chair of the Network of Ethnic Physician Organizations (NEPO), as well as a Delegate Chair for the Ethnic Medical Organization Section (EMOS) of the California Medical Association's (CMA). Dr. Juarez noted that respondent has attended NEPO and EMOS

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[5] Government Code section 11513, subdivision (d), in relevant part, provides:

> Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions

functions, and was recently elected as a EMOS Delegate for the annual meeting of the House of Delegates. Dr. Juarez has served on the credentialing committee for the Board, and asserted that interpretations of physician behavior is complicated, especially for physicians of color. She further asserted that female physicians are often exposed to "another level of standard" and are more vulnerable than their male counterparts. Dr. Juarez believes the state of California needs physicians of diverse backgrounds and would benefit from respondent's point of view, life experiences, and accomplishments.

Dr. Pham is a fellow member of EMOS and has worked alongside respondent on many occasions, reviewing resolutions to be considered for adoption by CMA. He commended respondent for being "extremely knowledgeable of the issues that affect her patients" and for providing testimonials that influenced the CMA's disapproval of harmful proposals. He further noted that respondent "showed dedication and commitment to serve not only her patients, but all patients who fall outside her practice

Discussion

116. Complainant bears the burden of demonstrating through clear and convincing evidence that respondent's ability to practice medicine is impaired due to mental illness affecting her competency. The Board has the authority to order a physician to be examined by a psychiatrist designated by the Board, and based upon the examination findings to take such action as the Board in its discretion deems proper. (Bus. & Prof. Code, §§ 820, 822.) If the physician's license is revoked or suspended, the Board shall not reinstate the license until it has received competent evidence of the absence or control of the condition, or is satisfied that the physician may be safely reinstated.

117. Respondent was evaluated pursuant to section 820 on August 18, 2017. Dr. Lavid engaged in a thorough review of respondent's available neurological, medical and psychiatric history, and the events during her brief employment with Orchard Clinic. He prepared a comprehensive report and addendum that described respondent's paranoia and persecutory type delusional disorder. The numerous examples detailed in this case, including respondent unreasonably accusing others of yelling at her, spying on others' conversations to see if they are talking about her, accusing other physicians of being pill mills, alleging a complaining patient tested positive for cocaine with no supporting proof, and accusing Orchard Clinic and the Board of retaliation due to a federal complaint she had not filed yet, support Dr Lavid's assessment that respondent believes she is being maliciously maligned by others and that the temporal relationship of respondent's version of events is nonsensical.

Dr. Lavid explained how respondent's condition negatively impacts her ability to practice medicine safely. Respondent is a primary care physician. She must be able to perceive reality accurately when she examines patients, makes diagnoses, and recommends plans for treatment. She must have the ability to accurately document what occurred during the patient visit. Dr. Lavid opined that respondent is unable to do so due to her mental condition. Respondent offered no medical expert witness testimony to counter Dr. Lavid's opinion.

118. Dr. Lavid's psychiatric evaluation of respondent occurred almost two years ago. However, at hearing, respondent continued to exhibit symptoms described in the evaluation and addendum. Respondent had difficulty providing direct answers upon cross-examination. She frequently deflected blame to others – CEO Stark, Dr. Starkes, Dr. Winshall, her patients – rather than accept responsibility for her own actions. She asserted every witness was influenced by an improper bias against her based on religion and culture without any corroborating evidence.

119. The above matters and the record in this case having been considered, as well the parties' closing arguments. Complainant established through clear and convincing evidence that respondent has a mental illness affecting competency. Complainant presented competent psychiatric evidence that respondent's ability to practice medicine is impaired due to a mental condition, persecutory type delusional disorder. This condition impacts respondent's ability to safely engage in the practice of medicine at this time.

Appropriate Discipline/Restriction

120. Patient Care. As set forth in Findings 31 through 90, complainant established by clear and convincing evidence that respondent's care for the eight identified patients constituted an extreme departure of care., and that she committed repeated negligent acts as to each identified patient. Dr. Hilzinger wrote a comprehensive and detailed report outlining the applicable standard of care and how respondent's action or lack of action repeatedly fell below it. Respondent offered no medical expert testimony to counter Dr. Hilzinger's opinion. Respondent admitted that she did not maintain accurate records of patient visits, and offered no evidence to corroborate her own testimony that she performed appropriate patient care. Respondent's testimony was not credible as she repeatedly contradicted herself and her own prior statements. Respondent's credibility was also tarnished by the fact that she entered false information to an addendum to Patient J.G.'s medical record.

121. Protection of the public shall be the highest priority in exercising the Board's disciplinary authority. (Bus. & Prof. Code, § 2229, subd. (a).) When exercising such authority, the Board shall take action that is calculated to aid in the rehabilitation of the licensee. (Bus. & Prof. Code, § 2229, subd. (b).) However, where rehabilitation and protection are inconsistent, "protection shall be paramount." (Bus. & Prof. Code, § 2229, subd. (c).) The Board has adopted model disciplinary guidelines that provide for respondent's conduct a minimum penalty of stayed revocation with a five-year probation, and a maximum penalty of revocation.

A determination of rehabilitation requires consideration of the offense from which one has allegedly been rehabilitated. In this case, respondent has not taken an essential step towards rehabilitation: full acknowledgment of prior wrongdoing. (See, *Seide v. Committee of Bar Examiners of the State Bar of California* (1989) 49 Cal.3d 933, 940 ["Fully acknowledging the wrongfulness of his actions is an essential step towards rehabilitation"].)

122. Mental Condition. The matters set forth in Findings 6 through 30 have also been considered. Complainant presented competent psychiatric evidence that respondent's

ability to practice medicine is impaired due to a mental condition, persecutory type delusional disorder. This condition impacts respondent's ability to safely engage in the practice of medicine at this time. Dr. Lavid's medical evaluation and opinions were thoughtful, well supported by respondent's history and behaviors, and well explained in his report, addendum, and testimony at hearing. His summary and recommendations in this case are persuasive and entitled to considerable deference given his professional background and expertise.

123. No consideration should be given to placing respondent on probation at this time. Probation will neither facilitate improvement in her mental condition nor promote rehabilitation. Doing so would also be contrary to the Board's public protection mandate. For these reasons respondent's medical license must be revoked.

LEGAL CONCLUSIONS

1. The Medical Practices Act, Business and Professions Code section 2000, et seq., provides that "protection of the public shall be the highest priority for the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

2. Complainant has the burden of proving each of the grounds for discipline alleged in the First Amended Accusation, and must do so by clear and convincing evidence. (See, *Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The evidence must be so clear as to leave no substantial doubt, and must be sufficiently strong that it commands the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84 [citations omitted].)

Applicable Law

3. Business and Professions Code section 820 provides:

> Whenever it appears that any person holding a license, certificate or permit under this division or under any initiative act referred to in this division may be unable to practice his or her profession safely because the licentiate's ability to practice is impaired due to mental illness, or physical illness affecting competency, the licensing agency may order the licentiate to be examined by one or more physicians and surgeons or psychologists designated by the agency. The report of the examiners shall be made available to the licentiate and may be received as direct evidence in proceedings conducted pursuant to Section 822.

4. Business and Professions Code section 822 provides that a licensing agency may take disciplinary action where it determines that its "licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency."

5. Business and Professions Code section 2227 provides in pertinent part that a licensee that has been found "guilty" of violations of the Medical Practices Act, shall:

> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

6. Business and Professions Code, section 2234, requires the Board to "take action against any licensee who is charged with unprofessional conduct." Unprofessional conduct includes, but is not limited to gross negligence and repeated negligent acts. (Bus. & Prof. Code, § 2234, subds. (b) & (c).) "To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts." (Bus. & Prof. Code, § 2234, subd. (c).) The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052. Simple negligence is merely a departure from the standard of care.

7. Unprofessional conduct also includes "knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine . . . which falsely represents the existence or nonexistence of a state of facts." (Bus. & Prof. Code, § 2261. Finally, "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients" constitutes unprofessional conduct. (Bus. & Prof. Code, § 2266.)

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Causes for Restriction / Discipline

8. Cause for license restriction exists under Business and Professions Code sections 820 and 822, by reason of the matters set forth in Findings 6 through 32, and 116 through 119, and 122. Complainant presented competent medical/psychiatric evidence that respondent's ability to practice medicine is impaired due to a mental condition, persecutory type delusional disorder. This condition impacts respondent's ability to safely engage in the practice of medicine at this time.

9. Cause for license discipline exists for gross negligence under Business and Professions Code section 2234, subdivision (b), by reason of the matters set forth in Findings 33 through 90, and 120. The treatment respondent provided to the eight identified patients constituted an extreme departure from the standard of care.

10. Cause for license discipline exists for repeated negligent acts under Business and Professions Code section 2234, subdivision (c), by reason of the matters set forth in Findings 33 through 90, and 121.

11. Cause for license discipline exists for falsification of medical records under Business and Professions Code section 2261, by reason of the matters set forth in Findings 54 through 57, 68, 76, 85 and 86. After being notified of an inadequate entry in the EMR, respondent entered an addendum stating that she examined patient J.G. when no examination had been performed.

12. Cause for license discipline exists for failing to maintain adequate and accurate medical records under Business and Professions Code sections 2234 and 2266, by reason of the matters set forth in Findings 33 through 90, and 121.

Appropriate Discipline / Restriction

13. The matters set forth in Findings 120 through 123 have been considered. Respondent did not present sufficient evidence of rehabilitation to warrant consideration of placing her on probation at this time.

14. Complainant presented competent medical/psychiatric evidence that respondent's ability to practice medicine remains impaired due to a mental condition, persecutory type delusional disorder. This condition impacts respondent's ability to safely engage in the practice of medicine at this time. Accordingly, public protection demands that respondent's medical license be revoked.

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ORDER

Physician's and Surgeon's Certificate No. A 116932, issued to respondent Hanna Queen Rhee, M.D., is hereby REVOKED.

DATED: June 17, 2019

DocuSigned by:
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TIFFANY L. KING
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
MEGAN R. O'CARROLL
Deputy Attorney General
State Bar No. 215479
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-5288
Facsimile: (916) 327-2247

Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **Hanna Queen Rhee, M.D.** **3010 Wilshire Blvd., Ste. 496** **Los Angeles, CA 90010-1103** **Physician's and Surgeon's Certificate No. No. A 116932,** Respondent.	Case No. 800-2015-018187 OAH No. 2018030315 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about May 11, 2011, the Medical Board issued Physician's and Surgeon's Certificate No. Number A 116932 to Hanna Queen Rhee, M.D. (Respondent). The Physician's

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and Surgeon's Certificate No. A 116932 was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2020, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

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"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2261 of the Code states: "Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their Patients constitutes unprofessional conduct."

8. Section 820 of the Code states:

"Whenever it appears that any person holding a license, certificate or permit under this division or under any initiative act referred to in this division may be unable to practice his or her profession safely because the licentiate's ability to practice is impaired due to mental illness, or physical illness affecting competency, the licensing agency may order the licentiate to be examined by one or more physicians and surgeons or psychologists designated by the agency. The report of the examiners shall be made available to the licentiate and may be received as direct evidence in proceedings conducted pursuant to Section 822."

9. Section 821 of the Code provides that the licentiate's failure to comply with an order issued under section 820 shall constitute grounds for the suspension or revocation of the licentiate's certificate of license.

10. Section 822 of the Code states:

"If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

"(a) Revoking the licentiate's certificate or license.

"(b) Suspending the licentiate's right to practice.

"(c) Placing the licentiate on probation.

"(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

"The licensing section shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated."

CAUSE FOR ACTION

(Mental or Medical Condition Affecting Competency)

11. Respondent began working as a locum tenens physician at the Orchard Hospital Medical Specialty Center in Gridley, California in or about March of 2015. During May of 2015, Orchard Hospital Medical Specialty Center signed a three-year employment contract with Respondent, but she resigned during investigation after only five months. During the five months that she was working at the Medical Specialty Center, there were a number of patient and staff complaints regarding her care and treatment of patients.

12. On or about November 17, 2015, the Medical Board of California (Board) received a report under Business and Professions Code section 805 indicating that Respondent resigned her privileges at Orchard Hospital Medical Specialty Center in Gridley, California while an investigation was pending, and the resignation was effective September 17, 2015. The investigation was due to a number of patients and staff members registering complaints about Respondent's behavior and her clinical competence.

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13. On or about January 7, 2016, the Board received a letter from one of Respondent's former coworkers, a physician. The letter stated that he had left the Medical Specialty Center in Gridley, due in part to harassment from Respondent. He was writing to ensure that the hospital had reported her conduct to the Board and that the Board would be investigating her. He reported his belief that Respondent is an incompetent physician with possible psychiatric problems.

14. The Board opened an investigation into the facts and circumstances surrounding Respondent's resignation while under investigation by Orchard Hospital Medical Specialty Center. During the investigation, Board investigators gathered documents and interviewed patients and staff. Several nurses and medical assistants who worked with Respondent reported that Respondent had a phobia of germs and refused to shake hands, instead offering an "elbow bump" to greet others. The administrative staff at Orchard Hospital Medical Specialty Center also received several patient complaints that Respondent would not touch or examine them when they presented for appointments. A Medical Assistant who had worked with Respondent indicated that she never once observed Respondent touch a patient during an appointment. Several staff members reported that Respondent refused to see male, Hispanic patients after 4:00 p.m., or to perform genital examinations on male patients. Other physicians and nurse practitioners at the Medical Specialty Clinic reported Respondent failed to properly examine or treat patients for serious conditions requiring immediate medical attention. Instead, she would make new appointments for these patients with the other practitioners a few days after she had seen them in their initial appointments herself.

15. On or about January 3, 2017, Board investigators interviewed Respondent about the events surrounding her resignation from Orchard Hospital Medical Specialty Center. Respondent confirmed that she did not perform genital examinations on patients, but stated that this was due to her lack of qualification to conduct genital examinations. However, in subsequent correspondence with Orchard Hospital Medical Specialty Center she claimed her refusal to perform genital examinations was due to "moral" and "religious" issues.

16. Board investigators also learned that the staff at the Medical Specialty Center had observed Respondent displaying bizarre behaviors in her interactions with other staff members.

For example, the Chief of Staff reported that Respondent often accused him and others of yelling at her despite everyone using a normal tone and volume of voice. In addition, he reported that Respondent had been spending nights in the clinic, even after being asked not to be present unless she was scheduled to work. He noted that she kept a bedroll and sleeping bag under her desk.

17. The Director of the Medical Specialty Center reported that she received complaints from several staff members that they caught Respondent going through their mail and listening surreptitiously at doors to conversations others were having. The Medical Director explained that when Respondent was confronted about this behavior she did not deny it. Respondent was counseled and issued a formal warning letter on or about August 5, 2015, for listening at doors to private conversations, going through other individuals' desks and mailboxes, and accessing medical records of individuals who were not her patients in violation of privacy protections.

18. On or about Saturday, August 29, 2015, approximately two weeks after the Chief of Staff had instructed Respondent not to be present at the facility when she was not scheduled to work, a strange incident occurred at the Medical Specialty Center. Respondent spoke to the Director by telephone reporting that she felt unsafe because another physician present was threatening her. The Director explained that the physician was authorized to be at the facility that day, and Respondent was not authorized to be present, and Respondent should leave immediately. The Director required Respondent to verbalize that she was leaving the facility. Respondent did so. The Director then proceeded to the facility, without warning Respondent that she was going there. When the Director arrived approximately 20 minutes later, Respondent was still present in the building, and claimed to be barricaded in her office for protection. The Director saw Respondent off the premises.

19. On or about July 28, 2017, the Board issued an order compelling Respondent to undergo a mental evaluation. On or about August 18, 2017, Respondent was evaluated by a Board-certified psychiatrist who concluded that Respondent exhibits paranoid thoughts, which fit within a persecutory delusional disorder. Based on the materials provided to him, and his interview with Respondent, he found that many of Respondent's paranoid delusional thoughts are attributed to medical institutions. Given that a physician is required to accurately interpret reality

in the medical field in order to practice medicine safely, he concluded that Respondent presently suffers from paranoia which could substantially impair her ability to safely practice medicine and that the public is in danger if Respondent is permitted to continue to practice medicine.

20. Respondent's conditions and actions as set forth above demonstrate that she has a physical or mental condition affecting her competency to practice medicine, thus subjecting her license to action under section 822 of the Code.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence, Patient 1)

21. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (b) of the Code in that she was grossly negligent in the care and treatment of Patient 1.[1] The circumstances are as follows:

22. Respondent first saw Patient 1 on or about March 16, 2015. Patient 1 had a past medical history of coronary artery disease, heart attack in 2014, with multi-organ failure requiring dialysis, Crohn's disease, Barrett's esophagitis, a coccyx decubitus and pneumonia. He had been seen recently in the Emergency Room for pneumonia. His current medications were listed.

23. Respondent documented an examination that did not correspond to the prescriptions and medical history of Patient 1, and frequently contradicted other portions of the record. For example, Respondent documented that Patient 1 was well developed and nourished, but Patient 1 was specifically noted to be cachectic. The other systems were also described as normal despite recent history of admission to the Emergency Room, and ongoing treatment for chronic conditions. Respondent made no notations as to whether or not Patient 1 had shortness of breath with activity, chest pain with activity, or leg swelling, despite his history of heart disease. And despite Patient 1's recent Emergency Room visit for pneumonia, Respondent did not document his respiratory status or complaints. Respondent conducted no review of depressive symptoms, anxiety symptoms or ADD symptoms. Respondent noted that Patient 1 had a stage 3 pressure ulcer of the coccyx, which was 2 by 2 centimeters.

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[1] The patients are referred to by numbers in this Accusation to protect their privacy.

24. Respondent's assessment and plan was listed as: 1) cardiac arrest, refer to cardiology; 2) ADD, no refills until old records and psych referral; 3) anxiety, continue Clonazepam; 4) depression, continue trazodone/psych consult; 5) asthma, continue proair inhaler; 6) pressure ulcer, refer to wound care and nutrition for cachexia; 7) pneumonia, continue z-pack. Respondent's notes did not explain the reason why Patient 1 was on pain medication.

25. Respondent saw Patient 1 again on or about March 27, 2015. Respondent noted Patient 1 to be "cachexic amphetamined'd cardiac arrest," multiple MI, chronic pain rule out opiate dependence, recent Emergency Room visit for ventricular tachycardia. Again Respondent's examination incorrectly stated that all of Patient 1's systems were normal and he was described as well nourished with no skin lesions, regular heart rhythms and no murmurs. The neck examination listed a normal range of motion and there was no back examination listed. Yet, at the end of the report of a normal examination, Respondent wrote "cachexic, cervical lumbar decrease range of motion no elicited pain." No further explanation was given.

26. Respondent's assessment and plan for the March 27, 2015 visit indicated that she was assessing him with cardiac arrest and unspecified cardiac arrhythmia, for which she referred him to cardiology and ordered an echocardiogram and to taper off the methylphenidate. There was no indication given for the echocardiogram, and Respondent did not establish a taper of the methylphenidate. Instead Respondent refilled the methylphenidate prescription at the same dose. Respondent referred Patient 1 to radiology for his cardiac history, but did not indicate why. Respondent referred Patient 1 to psychiatry and refilled the current medications. For the GERD, which was not discussed in the history, Respondent directed Patient 1 to stay on Nexium. As to the chronic pain due to trauma, Respondent did not document a history of trauma, and the medical record only noted neck and back pain in the assessment. Nonetheless, Respondent ordered a spinal survey, directed a taper of medication and referred Patient 1 to pain management. For the cachexia, Respondent referred Patient 1 to nutrition. Patient 1 was to follow up in two weeks.

27. Respondent saw Patient 1 in follow up on or about April 17, 2015 to review the echocardiogram results and spine x-ray results. Patient 1 reported that his left arm was going

numb, and that three weeks ago he had decreased sensation in his right hand. He reported he had burned his right hand on the stove, and could not move it well. He also reported that decreased sensation of his left hand and a burning pain like frostbite, with no recollection of any injury to the area. Respondent again noted that Patient 1 needed to taper off the methylphenidate, and again did not establish a taper. Respondent again noted that Patient 1's review of systems and examination to be normal, and again incorrectly noted Patient 1 to be well nourished. The neck examination was again noted to be normal, and the range of motion was normal. There was no documented neurological examination, and only a statement that the right upper extremity was "less sensory, decreased grip, ad normal range of motion and 2+ pulses." The left hand was noted to be "less sensory, normal motor, range of motion and 2+ pulses."

28. Respondent's assessment and plan for Patient 1 noted chronic pain and trauma, for which she ordered an MRI with and without contrast for the cervical thoracic and lumbar spine. Respondent stated she ordered the MRI because Patient 1 had a stage three coccyx ulcer/abscess and had complained of headache that woke him up, a stiff neck, and problems with concentrating. Second, Respondent noted that Patient 1 had unspecified neuralgia, neuritis, and radiculitis. She indicated she wanted the spinal MRI to rule out meningitis mass or degenerative disc disease. The third item on the assessment and plan listed cellulitis and abscess of an unspecified site. For this finding Respondent ordered serum uric acid, Vitamin D 25-hydroxy, testosterone, free and total, lipid panel, basic metabolic panel, and a CBC. She indicated no reason for these tests. Respondent's chart note indicated "'It's worse than I thought' rocephn'd. Plan: fasting labs decline tap, MRI, monitor refer hayes, f/u ncv." Patient 1 was then given an injection of Rocephin and Sensorcaine by a nurse. The end of the chart note indicated that Patient 1 was to follow up Tuesday afternoon with the reason listed as "wound, refer hayes." Patient 1 passed away a few days after that visit.

29. Respondent was grossly negligent in her care and treatment of Patient 1, for her acts including, but not limited to, the following:

A. Failing to perform and document an adequate and accurate history and physical that comported with her assessment of Patient 1;

B. Documenting that Patient 1 was well developed and nourished despite the fact that he was cachectic;

C. Failing to document respiratory symptoms in a patient with recent pneumonia;

D. Failing to document cardiac symptoms in a patient with a history of cardiac arrest and arrhythmia;

E. Failing to document the symptoms of ADD, anxiety or depression;

F. Failing to note the reason Patient 1 was on pain medications;

G. Failing to document the sensory examination as "less sensory," which omits significant clinical information;

H. Failing to documenting the results of echo or spinal x-ray she ordered;

I. Failing to provide testing and treatment consistent with the physical exam findings, assessments, and differential diagnoses;

J. Failing to provide a methylphenidate taper and instead refilling the prescription despite instructing Patient 1 to taper;

K. Injecting Rocephin for reasons not explained or documented in record;

L. Directing Patient 1 to transition to methadone for abscess of an unspecified site with no explanation regarding why cellulitis was assessed; and

M. Ordering lab tests and imaging not indicated by the examination or history.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts, Patient 1)

30. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (c), of the Code, in that she was repeatedly negligent in the care and treatment of Patient 1.

31. Paragraphs 21 through 29, above, are incorporated by reference and repeated as if set forth.

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32. Respondent was repeatedly negligent in her care and treatment of Patient 1 for her acts including, but not limited to, the following:

A. Failing to perform and document an adequate and accurate history and physical that comported with her assessment of Patient 1;

B. Documenting that Patient 1 was well developed and nourished despite the fact that he was cachectic;

C. Failing to document respiratory symptoms in a patient with recent pneumonia;

D. Failing to document cardiac symptoms in a patient with a history of cardiac arrest and arrhythmia;

E. Failing to document the symptoms of ADD, anxiety or depression;

F. Failing to note the reason Patient 1 was on pain medications;

G. Failing to document the sensory examination as "less sensory," which omits significant clinical information;

H. Failing to documenting the results of echo or spinal x-ray she ordered;

I. Failing to provide testing and treatment consistent with the physical exam findings, assessments, and differential diagnoses;

J. Failing to provide a methylphenidate taper and instead refilling the prescription despite instructing Patient 1 to taper;

K. Injecting Rocephin for reasons not explained or documented in record;

L. Directing Patient 1 to transition to methadone for abscess of an unspecified site with no explanation regarding why cellulitis was assessed; and

M. Ordering lab tests and imagining not indicated by the examination or history.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence, Patient 2)

33. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (b), of the Code, in that she was grossly negligent in the care and treatment of Patient 2. The circumstances are as follows:

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34. Patient 2 was a 58-year-old woman who saw Respondent on or about May 11, 2015, complaining of shortness of breath and diarrhea for the previous week. Patient 2's past medical history listed Type 2 diabetes, anxiety, heart attack, neuropathy of the arms and legs, depression, COPD, high cholesterol, hypertension, chronic pain, and allergy to outside air. Respondent charted a review of systems for Patient 2 that did not include any symptoms involving shortness of breath or diarrhea. Under the "Examination" section of the chart, Respondent wrote, " Gait Analysis: SOB at rest "'i don't want to go to the ER...i won't go to the ER', high bp asymp, stable. Ao x3 nad." During an interview with Board investigators, when asked about whether she performed an examination of Patient 2, Respondent stated that she did not document an examination because Patient 2 needed to go to the Emergency Room. However, there is nothing in the chart to indicate that Respondent directed or recommended Patient 2 go to the Emergency Room, or why.

35. Respondent's assessment and plan for Patient 2 listed four issues under the assessment, diarrhea, congestive heart failure unspecified, other and unspecified angina pectoris, and nausea. Respondent listed treatment in a five-part summary. The first was for unspecified angina pectoris. She prescribed nitroglycerin, immediately, 0.4 milligrams sublingually for the angina. Second, for the diarrhea she directed Patient 2 to take kaopectate. Third, for the congestive heart failure she noted Patient 2 had recently seen a cardiologist who ordered Imdur. Respondent further directed Patient 2 to also use the sublingual nitroglycerin for this. Fourth, for the nausea, Respondent noted Patient 2 had obtained relief from Phenergan in the past, and noted that the nausea was likely related to the cardiac condition. Patient 2 was then given an injection of Phenergan by the nurse. Respondent directed Patient 2 to follow up in two or three days.

36. Respondent was grossly negligent in her care and treatment of Patient 2 for her acts, including, but not limited to, the following:

A. Failing to perform and document an adequate and accurate history and physical that comported with her assessment of Patient 2; and

B. Failing to provide testing and treatment consistent with the physical exam findings, assessments, and differential diagnoses.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts, Patient 2)

37. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (c), of the Code, in that she was repeatedly negligent in the care and treatment of Patient 2.

38. Paragraphs 33 through 36, above, are incorporated by reference and repeated as if set forth.

39. Respondent was repeatedly negligent in her care and treatment of Patient 2 for her acts, including, but not limited to, the following:

A. Failing to perform and document an adequate and accurate history and physical that comported with her assessment of Patient 2; and

B. Failing to provide testing and treatment consistent with the physical exam findings, assessments, and differential diagnoses.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence, Patient 3)

40. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (b) of the Code in that she was grossly negligent in the care and treatment of Patient 3. The circumstances are as follows:

41. Patient 3 was a 50-year-old man who presented to the Medical Specialty Center in Gridley on or about July 5, 2015, with a history of genital pain for the previous three days. Respondent charted Patient 3's present complaint to be right scrotal pain, with no prior event, that came on suddenly. She noted he had pain of 4/10, and denied chest pain, dizziness, lightheadedness, stomach upset, dysuria, fever or chills, and nausea.

42. Respondent charted a review of systems with no positive findings. The examination note contained a template list of examinations with normal findings for General, Cardiac, Lungs, and Abdominal systems. Below these is an examination note with a heading "genital" that states, "no rash, hernia unable elicit pain." When discussing her care of Patient 3 with the Board's investigators, Respondent initially reinforced that she does not do genital examinations, and

explained that she had the interpreter present explain this to Patient 3. When the investigator asked her to explain what she meant in her chart note about not being able to elicit pain, however, Respondent stated that she palpated Patient 3's testicle. Upon further inquiry, she stated that she had no specific recollection of the Patient or whether she palpated the testicle. She further confirmed that she does not perform physical palpation of men to check for inguinal hernias, and therefore, she did not perform an internal palpitation of Patient 3's inguinal canal to check for a hernia.

43. Respondent did not order any cultures or urinalysis for Patient 3. She did not order a scrotal ultrasound. Respondent's assessment of Patient 3 was that of unspecified disorder of male genital organs. She prescribed Motrin, and directed him to follow up with his primary care physician. She did not indicate any timeframe for Patient 3 to follow up with his primary care physician. Although she reported that Patient 3's complaint of scrotal pain was not reproducible during her examination, Patient 3 was seen by another physician three days later who reported that his testicle was very painful during his appointment with Respondent.

44. Respondent was grossly negligent in her care and treatment of Patient 3 for her acts, including, but not limited to, the following:

A. Failing to order any cultures or urinalysis for Patient 3;

B. Failing to order a scrotal ultrasound;

C. Failing to consider a diagnosis of epididymitis; and

D. Failing to document or perform a physical examination.

SIXTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts, Patient 3)

45. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (c), of the Code, in that she was repeatedly negligent in the care and treatment of Patient 3. The circumstances are as follows:

46. Paragraphs 40 through 44, above, are incorporated by reference and repeated as if set forth.

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47. Respondent was repeatedly negligent in her care and treatment of Patient 3 for her acts, including, but not limited to, the following:

A. Failing to order any cultures or urinalysis for Patient 3;

B. Failing to order a scrotal ultrasound;

C. Failing to consider a diagnosis of epididymitis; and

D. Failing to document or perform a physical examination.

SEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence, Patient 4)

48. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (b), of the Code, in that she was grossly negligent in the care and treatment of Patient 4. The circumstances are as follows:

49. Patient 4 was seen by Respondent on or about September 1, 2015 for a follow up from the hospital. Respondent recorded that Patient 4 had been in the Emergency Room after drinking on her birthday. She was reportedly not feeling well and was shaky. Respondent recorded that the Patient's blood work in the Emergency Room showed that she had low magnesium and sodium. The review of systems Respondent charted was all listed as normal. Respondent charted an examination containing the same template language seen in other records for General, Cardiac, and Lungs, finding no positive signs. Respondent's recorded examination continued, noting that the Patient had bilateral conjunctival injection, nasal terminates boggy grey and wheezing breathing, resting fine motor tremor both hands, she appeared anxious, denied suicidal ideation, had no guns and the CAGE (a problem drinking screen) was negative. The finding of wheezing contradicted the template language under the lung examination finding the lungs clear to auscultation bilaterally.

50. Respondent listed five findings under assessment for Patient 4, which were Allergy, encounter for long-term use of medications, elevated blood pressure, anxiety, and alcohol withdrawal. The treatment plan had no plan to correspond with the anxiety assessment. For the alcohol withdrawal, Respondent prescribed Klonopin, 1 milligram orally, twice per day. For the allergy assessment, Respondent prescribed an albuterol inhaler and Claritin tablets. For long term

use of medication, Respondent ordered a number of lab tests including uric acid, hemoglobin A1c, magnesium, lipid panel, thyroid tests, basic metabolic panel, CBC, sed rate, liver function test, urine micro albumin and a CRP. There was no explanation as to why each of these tests was ordered. The plan for the elevated blood pressure was a low salt diet and monitoring. She was directed to follow up in one week.

51. The following day, on or about September 2, 2015, Patient 4's brother went to the Medical Specialty Center regarding concerns he had with the care provided to his sister, and specifically his concern with the prescription for Klonopin. He attempted to speak with Respondent, but she stated she was busy with other work, could not hear him, and was concerned with potential privacy issues in speaking about the patient. She directed him to write down any concerns he had.

52. Patient 4's brother left a detailed note for Respondent explaining that Patient 4 was recently detoxed for alcohol at Orchard Hospital Emergency Room on or about August 1, 2015. Her blood alcohol level on that occasion was .72%. He stated that Patient 4 was suicidal and had been placed on involuntary mental health holds four times in the past and had texted a suicide note to him in the last few days. Patient 4's brother expressed concern that Respondent had prescribed Klonopin to a suicidal patient, given the contraindications of alcohol use and suicidal ideation. He further indicated that Patient 4 was non-compliant with medications and that he had located several months of unused medications, and that her blood pressure at the Emergency Room was 215/160, due to alcohol consumption. Respondent indicated in her interview with Board investigators that she had no access to hospital records of Patient 4 that may have contained a history that Patient 4's brother reported.

53. Respondent was grossly negligent in her care and treatment of Patient 4 for her acts, including, but not limited to, the following:

A. Failing to obtain and document an accurate and adequate history in spite of information being offered by a relative;

B. Failing to indicate the reason for many of the lab tests ordered;

C. Failing to order a folate test or prothrombin test; and

D. Providing improper treatment for alcoholism by failing to refer to inpatient treatment and failure to prescribe thiamine or multi-vitamin.

EIGHTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts, Patient 4)

54. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (c), of the Code, in that she was repeatedly negligent in the care and treatment of Patient 4. The circumstances are as follows:

55. Paragraphs 48 through 53, above, are incorporated by reference and repeated as if set forth.

56. Respondent was repeatedly negligent in her care and treatment of Patient 4 for her acts, including, but not limited to, the following:

A. Failing to obtain and document an accurate and adequate history in spite of information being offered by a relative;

B. Failing to indicate the reason for many of the lab tests ordered;

C. Failing to order a folate test or prothrombin test; and

D. Providing improper treatment for alcoholism by failing to refer to inpatient treatment and failure to prescribe thiamine or multi-vitamin.

NINTH CAUSE FOR DISCIPLINE

(Gross Negligence, Patient 5)

57. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (b) of the Code in that she was grossly negligent in the care and treatment of Patient 5. The circumstances are as follows:

58. Patient 5 was a 66-year-old man when he was seen by Respondent on or about September 2, 2015. Patient 5 was being seen for evaluation of anxiety and because his previous provider had left the clinic and he was establishing care with Respondent. Patient 5 was requesting a refill for Ativan for anxiety and for Nasonex for his allergies. Respondent documented that Patient 5 was an alcoholic but had quit last month and that he had been seen by a cardiologist six months ago for an enlarged heart. Respondent also documented that Patient 5 had

shortness of breath and cannot walk more than five feet, which is normal for him as he is always short of breath. Respondent documented Patient 5's past history as having COPD, an enlarged heart, and seizures. Patient 5's vital signs were charted with a blood pressure of 180/121 and a heart rate of 122. Under examination, Respondent listed that Patient 5 was alert, in no acute distress, his heart was irregular with no murmurs gallops or rubs, his lungs had decreased respiration bilateral lower lobes, with rapid shallow wheezing throughout. Respondent then recorded, "No I won't go to the ER... I don't want to go, .2 clonidined, ok... I'll go to the ER...but I can't walk there because I can't breathe."

59. Respondent's assessment for Patient 5 provided five entries: (1) encounter for long term use of other medications; (2) hypertrophy (benign) of prostate without urinary obstruction; (3) chronic airway obstruction; (4) hypertension; and (5) atrial fibrillation. Her plan for the long term use of medications was again to perform a series of laboratory tests without specific indications noted for the tests. No plan was listed for the hypertrophy of prostate. For the airway obstruction, hypertension and atrial fibrillation, the plan was to go to the Emergency Room, and Respondent further ordered clonidine, and provided a referral to pulmonology.

60. Respondent called the Emergency Room physician to advise that she was sending Patient 5 to them for treatment of tachycardia and hypertension. He arrived via wheelchair, and upon evaluation his blood pressure was 140/101 and his heartrate was 104. His oxygen saturation was 98% and he was mildly short of breath. He reported that he had quit drinking and smoking marijuana for the last month and had explained to Respondent that he was experiencing severe anxiety to the point of blacking out. He reported that Respondent had refused to refill the Ativan as she stated she did not believe in it and that he felt the need to get away from Respondent. He stated that if his doctor did not care about his sobriety he felt like he should start drinking again. The Emergency Room confirmed Patient 5 had been on Ativan and refilled this for one week while making an appointment for him to see another provider in a week.

61. The following week Patient 5 saw another provider at the Medical Specialty Center who changed him to Valium to help him with the withdrawal symptoms and prescribed ReVia to

help with alcohol cravings. She provided support and guidance on addiction issues and obtained imaging for his other medical conditions.

62. Respondent was grossly negligent in her care and treatment of Patient 5 for her acts, including, but not limited to, the following:

A. Failing to perform or document an appropriate examination of a patient with decreased respiration and irregular heartrate;

B. Failing to document the reason for the referral to the Emergency Room;

C. Failing to conduct an adequate history and examination of urinary and prostate symptoms; and

D. Failing to provide testing and treatment consistent with the physical exam findings, assessments, and differential diagnoses.

TENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts, Patient 5)

63. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (c) of the Code in that she was repeatedly negligent in the care and treatment of Patient 5.

64. Paragraphs 57 through 62, above, are incorporated by reference and repeated as if set forth.

65. Respondent was repeatedly negligent in her care and treatment of Patient 5 for her acts, including, but not limited to, the following:

A. Failing to perform or document an appropriate examination of a patient with decreased respiration and irregular heartrate;

B. Failing to document the reason for the referral to the Emergency Room;

C. Failing to conduct an adequate history and examination of urinary and prostate symptoms; and

D. Failing to provide testing and treatment consistent with the physical exam findings, assessments, and differential diagnoses.

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ELEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence, Patient 6)

66. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (b), of the Code, in that she was grossly negligent in the care and treatment of Patient 6. The circumstances are as follows:

67. Patient 6 was a 26-year-old woman when she saw Respondent on or about August 2, 2015. She complained of having dizziness for the previous week. Respondent recorded that Patient 6 was dizzy and hears liquid in her ears and had been diagnosed with vertigo by a previous provider. She took Claritin nasal spray. Patient 6 stated she has taken meclizine in the past, but it made her drowsy, and that she experienced symptoms each time she got a cold or allergies. Patient 6 provided further history that she had two sisters with vertigo; she had a recent abnormal menstrual period and had an EKG performed a few months ago. Respondent charted a review of systems that was generic and appeared similar to the template notes frequently found in the other patients in which Respondent's treatment is being reviewed. The physical examination did not document neck, ear, or eye exams. Respondent did document bradycardia with a recorded heart rate of 58.

68. Respondent listed four issues under assessment: (1) encounter for long term use of other medications; (2) unspecified peripheral vertigo; (3) cardiac dysrhythmias; and (4) rule out pregnancy. The plan corresponding to the encounter for long term medications was to perform laboratory tests including vitamin b12, vitamin D, lipid panel, TSH and free T4, basic metabolic panel, CBC test, liver function test, and pregnancy test. For the unspecified vertigo and cardiac arrhythmias, Respondent ordered a holter monitor and promethazine and antihistamine, with fall prevention being monitored. For the potential pregnancy, Respondent ordered the pregnancy test. Patient 6 was to follow up in one week.

69. Patient 6 was next seen by Respondent on or about August 7, 2015. Respondent diagnosed her hypothyroidism at this visit based on her thyroid tests. The tests showed she had a TSH level of 1.86, and a free T4 value of .71. Patient 6's tests results were not actually diagnostic for hypothyroidism, because the normal test results are generally considered to be .47-

4.68 and .7-2.19, for TSH and T4, respectively. Respondent prescribed levothyroxine, 25 milligrams, once per day. Patient 6 reported that Respondent never touched or examined her during either of the two appointments.

70. Patient 6 was seen by another practitioner two days later complaining of a rapid heart rate and change of mood after taking the new medication, as well as having a feeling of a swollen throat and poor appetite. The other practitioner stopped the levothyroxine and ordered repeat thyroid function tests.

71. Respondent was grossly negligent in her care and treatment of Patient 6 for her acts, including, but not limited to, the following:

A. Failing to document or perform an examination of the neck, ears and gait, and failure to perform an eye examination of the eyes, including a test for nystagmus;

B. Providing an improper diagnosis and treatment for hypothyroidism; and

C. Failing to provide testing and treatment consistent with the physical exam findings, assessments, and differential diagnoses.

TWELFTH CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence, Patient 6)

72. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (c), of the Code, in that she was repeatedly negligent in the care and treatment of Patient 6.

73. Paragraphs 66 through 71, above, are incorporated by reference and repeated as if set forth.

74. Respondent was repeatedly negligent in her care and treatment of Patient 6 for her acts, including, but not limited to, the following:

A. Failing to document or perform an examination of the neck, ears and gait, and failure to perform an eye examination of the eyes, including a test for nystagmus;

B. Providing an improper diagnosis and treatment for hypothyroidism; and

C. Failing to provide testing and treatment consistent with the physical exam findings, assessments, and differential diagnoses.

THIRTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence, Patient 7)

75. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (b), of the Code, in that she was grossly negligent in the care and treatment of Patient 7. The circumstances are as follows:

76. Patient 7 was a 63-year old patient when she saw Respondent on or about July 21, 2015 with a complaint of left hand pain. She reported she woke up with pain at 9/10 on her left hand. Respondent recorded that she performed an examination of Patient 7. Respondent wrote under "assessment" that Patient 7 had a rash and other nonspecific skin eruption, personal history of tobacco use, and dehydration. Under "plan," Respondent stated that the rash appeared consistent with scalding or toxic exposure and referred her to the Emergency Room, but also apparently issued a referral to a dermatologist.

77. Patient 7 was seen that same day at the Emergency Room. The Emergency Room physician's examination recorded that Patient 7 had a rash on the left hand and palm, with induration, tenderness, thickening, inflammation and crusting. He diagnosed her with contact dermatitis and cellulitis of the left hand. He prescribed Triamcinolone 0.5% cream to be applied to the hand three times daily and to return in two days if the symptoms had not improved.

78. Patient 7 complained that Respondent did not unwrap the bandages on her hand to examine her before referring her to the Emergency Room or to dermatology.

79. Respondent was grossly negligent in her care and treatment of Patient 7 in that she documented an examination that was not actually performed.

FOURTEENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts, Patient 7)

80. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (c), of the Code, in that she was repeatedly negligent in the care and treatment of Patient 7.

81. Paragraphs 75 through 79, above, are incorporated by reference and repeated as if set forth.

82. Respondent was repeatedly negligent in her care and treatment of Patient 7 in that she documented an examination that was not actually performed.

FIFTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence, Patient 8)

83. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (b), of the Code, in that she was grossly negligent in the care and treatment of Patient 8. The circumstances are as follows:

84. Patient 8 was a 76-year old woman, who saw Respondent on or about July 28, 2015, complaining of burning with urination, although she could not urinate at the time of the visit. Patient 8 also complained of tendonitis of the left shoulder and lower back. Respondent documented a ten-point assessment containing (1) nonspecific abnormal results of kidney function; (2) diabetes mellitus type two; (3) coronary artery disease; (4) malignant neoplasm of the breast; (5) malignant neoplasm of the middle lobe of lung; (6) malignant neoplasm of the lower lobe of lung; (7) unspecified ulcerative colitis (8) long term use of other medications (9) unspecified polyarthropathy; and (10) dysuria. Despite these serious conditions, there was no discussion or treatment provided for the coronary artery disease, long term medication use, polyarthropathy, or any of the malignancies. The ulcerative colitis and kidney functions tests similarly were not discussed and no symptoms or history were listed, even though there was a referral to gastroenterology; similarly the kidney function tests were never documented or discussed but there was a renal referral sent. The diabetes was not discussed or documented, except to indicate that Patient 8 should continue her medication and get yearly eye and foot examinations.

85. Respondent's charting under the assessment and review of systems have no information about any of the assessed conditions, except the dysuria. Respondent did not initially chart a physical examination of Patient 8 in the medical record, which she signed electronically on or about August 3, 2015.

86. On or about August 3, 2015, Patient 8 submitted a written complaint about Respondent stating that Respondent conducted no examination of her after the Medical Assistant

took her vital signs. After Patient 8's complaint was brought to Respondent's attention, Respondent added an addendum to Patient 8's record, on or about September 2, 2015, which stated, "notified of HER charting error. CORRECTION: gen a n o x3 and cardio RRR no MGR lung unremark sans Rt M.L psych pleasant coop."

87. Respondent was grossly negligent in her care and treatment of Patient 8 in that she documented an examination that was not actually performed.

SIXTEENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts, Patient 8)

88. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (c), of the Code, in that she was repeatedly negligent in the care and treatment of Patient 8.

89. Paragraphs 83 through 87, above, are incorporated by reference and repeated as if set forth.

90. Respondent was repeatedly negligent in her care and treatment of Patient 8 in that she documented an examination that was not actually performed.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Falsifying Medical Records)

91. Respondent Hanna Queen Rhee, M.D., is subject to disciplinary action under section 2261 of the Code in that she recorded a physical examination of Patient 8 that she did not perform.

92. Paragraphs 83 through 90, above, repeated here as if fully set forth.

EIGHTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence, Patient 9)

93. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (b), of the Code, in that she was grossly negligent in the care and treatment of Patient 9. The circumstances are as follows:

94. Patient 9 was a 54-year old man who had been having syncopal episodes on or about August 7, 2017, which caused his wife to call and make an appointment for him with his primary

care physician, Dr. B. His wife reported that as she was bringing Patient 9 to the clinic for the appointment he began having another syncopal episode in the parking lot. Respondent observed this and rushed out to the parking lot. She determined that he was having a cardiac event based on her observations of him, and provided him with nitroglycerin which she administered sublingually.

95. Respondent stated that she did not make any chart notes concerning her encounter with Patient 9 because it occurred outside the clinic, in the parking lot. Patient 9's wife reported that Respondent took no history and performed no examination before administering the nitroglycerin to her husband. Respondent was taken to the Emergency Room for treatment. At no time during the event did Patient 9 experience or report having any chest pain.

96. At the Emergency Room, Patient 9 was examined, and was determined to have bacterial pneumonia and dehydration. He was given antibiotics and kept in the hospital overnight for observation. The nurse who recorded the incident with Respondent reported that Respondent told her Patient 9's blood pressure was 74 over 34. Respondent denied this stating that it was not that low. However, nursing notes of Patient 9's treatment in the Emergency Room show that his blood pressure remained extremely low after he was taken to the Emergency Room. It was recorded at 70/40 upon admission. Approximately two and a half hours later, it was recorded to be 87/51. The nurse who reported the event involving Respondent's care of Patient 9 noted that his blood pressure remained in the range of 60's over 30's for approximately 90 minutes after the initial encounter with Respondent. He was observed closely for symptomatic hypotension and given intravenous fluids. Over the next hour, it rose to 80's over 40's, and eventually returned to the range of 90-106 over 50-60 diastolic. She recorded that when Patient 9 reached this level, his skin dried and he was no longer feeling so lightheaded.

97. Respondent was grossly negligent in her care and treatment of Patient 9 for her acts, including, but not limited to, the following:

A. Failing to take even a brief history or perform any examination before administering nitroglycerin;

B. Administering sublingual nitroglycerin to a patient without chest pain or any indication of a cardiac event; and

C. Failing to make any documentation of the incident in the medical record.

NINETEENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts, Patient 9)

98. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234, subsection (c), of the Code, in that she was repeatedly negligent in the care and treatment of Patient 9.

99. Paragraphs 93 through 97, above, are incorporated by reference and repeated as if set forth.

100. Respondent was repeatedly negligent in her care and treatment of Patient 9 for her acts, including, but not limited to, the following:

A. Failing to take even a brief history or perform any examination before administering nitroglycerin;

B. Administering sublingual nitroglycerin to a patient without chest pain or any indication of a cardiac event; and

C. Failing to make any documentation of the incident in the medical record.

TWENTIETH CAUSE FOR DISCIPLINE

(Failing to Maintain Adequate and Accurate Medical Records)

101. Respondent has subjected her license to disciplinary action under sections 2234 and 2266 of the Code by failing to maintain adequate and accurate records relating to the provision of services to Patients 1, 2, 3, 4, 5, 6, 7, 8 and 9.

102. Paragraphs 21 through 97, above are incorporated by reference and repeated as if set forth.

103. As set forth in paragraphs 21 through 100, Respondent failed to adequately and accurately document the provision of care to Patients 1, 2, 3, 4, 5, 6, 7, 8 and 9, thus subjecting her license to discipline.

TWENTY-FIRST CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

104. Respondent Hanna Queen Rhee, M.D. is subject to disciplinary action under section 2234 in that she has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as alleged in paragraphs 11 through 103 above, which are incorporated by reference and realleged as if fully set forth here.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 116932, issued to Hanna Queen Rhee, M.D.;

2. Revoking, suspending or denying approval of Hanna Queen Rhee, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Hanna Queen Rhee, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: November 16, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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