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

In the Matter of the Accusation   )
Against:                         )
 )
SUMIT MAHAJAN, M.D.             ) Case No. 18-2012-225972
Physician's and Surgeon's        ) OAH No. 2015021080
Certificate No. A 80732          )
) Respondent
)

DECISION

The Proposed Decision of H. Stuart Waxman, Administrative Law Judge, dated November 19, 2015 is attached hereto. Said decision is hereby amended, pursuant to Government Code section 11517(c)(2)(C), to correct technical or minor changes that do not affect the factual or legal basis of the proposed decision. The proposed decision is amended as follows:

1. Page 8, paragraph 6, the word “of” in the fourth line is stricken and replaced with “on”.

The Proposed Decision as amended is hereby accepted and 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 January 15, 2016.

IT IS SO ORDERED December 16, 2015.

MEDICAL BOARD OF CALIFORNIA

By: Howard Krauss, M.D., Chair
Panel B
PROPOSED DECISION

This matter came on regularly for hearing on November 9 and 10, 2015, in Los Angeles, California, before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California.

Martin W. Hagan, Deputy Attorney General, represented Kimberly Kirchmeyer (Complainant), Executive Director of the Medical Board of California (Board).

Sumit Mahajan (Respondent) was present and was represented by Robert W. Frank, Attorney at Law.

Oral and documentary evidence was received. The record was closed on November 10, 2015, and the matter was submitted for decision.

FACTUAL FINDINGS

1. Respondent is a board-certified internist who practices general medicine in the Yucca Valley area of California. He received his medical training in his native country of India and served his residency in internal medicine at Englewood Hospital and Medical Center, Mount Sinai School of Medicine, in Englewood, New Jersey. Respondent is presently Chief of Staff of the Hi-Desert Medical Center in Joshua Tree.
2. Respondent is alleged to have committed repeated negligent acts and to have failed to maintain adequate and accurate records in connection with his care and treatment of one patient at the Hi-Desert Family Health Clinic (clinic), a clinic established by the Hi-Desert Medical Center to treat post-operative, uninsured, and under-insured patients residing in the local area.

3. Complainant established the truth of the charging allegations contained in the Accusation, most of which were undisputed. Those allegations are repeated verbatim below and are incorporated herein as factual findings.

8. On or about November 1, 2011, patient S.B., a then fifty-nine-year-old female, had her first visit with respondent after her prior treating physician retired. Her chief complaints for this visit were recorded as “chronic opioid dependence,” a painful tongue and anxiety. The history of present illness indicated patient S.B. “has used opioids on a regular basis for 20 years,” was currently maintained on Vicodin ES [extra strength] three times a day, and had tried TENS (transcutaneous nerve stimulation) and physical therapy exercises at home with “some success.” According to the medical record for this visit, patient S.B. was not interested in pain management and was told during her last pain management session that “her osteoporosis precluded further epidural injections.” The patient was diagnosed and assessed with “anxiety, generalized” and “opioid dependence, unspecified.” The physical examination portion of the medical record included general notations concerning patient S.B.’s appearance and her cardiovascular, respiratory, gastrointestinal systems. Respondent did not conduct and/or failed to document any mouth/tongue or musculoskeletal examination; and there was no indication in the “past medical history” or “current problems” sections of the medical record for this visit concerning patient S.B.’s fibromyalgia.1 As part of this visit, respondent refilled patient S.B.’s prescriptions for Soma® (carisoprodol)2 350 mg, #100, one tablet to be taken

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1 The indications of patient SB’s fibromyalgia condition included, but [were] not limited to, one or more prior notations in the medical records of patient SB’s fibromyalgia; patient SB’s complaint to the Board indicating she discussed her fibromyalgia with respondent, the fact that respondent prescribed Lyrica which is typically used to treat the pain associated with fibromyalgia and a notation on the signed prescription indicating “Fibromyalgia.”

2 Soma is a brand name for carisoprodol, a muscle relaxant with a known potentiating effect on narcotics. In December, 2011, the Federal Drug Administration listed carisoprodol
orally tid (three times-a-day); Vicodin ES®
(hydrocodone/acetaminophen)³ 7.5 mg/750 mg tablet tid prn
(three times-a-day as needed); and Xanax (alprazolam)⁴ 1 mg,
#90, tid prn (three times-a-day as needed); and prescribed a new
medication, Lyrica (pregabalin).⁵ 50 mg, #60, 1 capsule orally
bid (twice-a-day). There was no indication in the medical
record concerning the basis for the new medication, Lyrica, nor
any indication of any discussion with the patient concerning the
new medication.

9. On or about November 15, 2011, patient S.B. had
her second visit with respondent. According to the medical
record for this visit, the chief complaints for this visit included a
painful tongue and an ingrown toenail. Respondent did not
conduct and/or failed to document any mouth/tongue
examination. The musculoskeletal examination for this visit
indicates “digits/nails: b/l ingrown toenails.” As part of this
visit, respondent prescribed Kelflex® [sic] (cephalexin)⁶
presumably for an infected ingrown toenail or toenails.
However, there is no documentation in the medical record for
this visit regarding any signs of infection. Respondent also
refilled patient S.B.’s prescription for Xanax (alprazolam) 1 mg,
#90, tid prn (three times-a-day as needed).

as a Schedule IV controlled substance, and a dangerous drug pursuant to Business and

³ Vicodin ES (hydrocodone 7.5 mg/acetaminophen 750 mg) is a Schedule III
controlled substance from the opiates class pursuant to Health and Safety Code section
11056, subdivision (c), and Title 21 of the Code of Federal Regulations, section 1308.13,
subdivision (e)(1)(iv), and is a dangerous drug pursuant to Business and Professions Code
section 4022.

⁴ Alprazolam is a schedule IV controlled substance from the benzodiazepine class,
pursuant to . . . Title 21 of the Code of Federal Regulations, section 1308.14, subdivision
(e)(1) and Health and Safety Code section 11057, subdivision (d), and is a dangerous drug
pursuant to Business and Professions Code section 4022.

⁵ Lyrica® (pregabalin) is an adjunctive pain medication which is frequently used to
treat fibromyalgia. Lyrica® is a Schedule V controlled substance pursuant to Health and
Safety Code section 11058, subdivision (b), and is a dangerous drug pursuant to Business
and Professions Code section 4022.

⁶ Kelflex® [sic] (cephalexin) is an antibacterial that can be used to treat skin
infections and is a dangerous drug pursuant to Business and Professions Code section 4022.
10. On or about December 2, 2011, patient S.B. had her third visit with respondent and she presented, again, with a chief complaint of a “painful tongue.” Respondent did not conduct and/or failed to document any mouth/tongue examination. As part of this visit, respondent refilled patient S.B.’s prescriptions for Soma® (carisoprodol) 350 mg, #100, one tablet tid (three times-a-day). Vicodin ES® (hydrocodone/acetaminophen) 75 mg/750 mg tablet tid prn (three times-a-day as needed); and Xanax (alprazolam) 1 mg, #90, tid prn (three times-a-day as needed).

11. On or about December 30, 2011, patient S.B. had her fourth visit with respondent. The chief complaint section of the medical record for this visit states, in pertinent part, “medical problems to be addressed today include DDD (degenerative disc disease).” The musculoskeletal examination for this visit indicates “decreased ROM with back flexion and extension, [and] pain with back flexion.” As part of this visit, respondent prescribed a new medication, Kadian® (morphine sulfate) 10 mg extended release capsules, #60, 1 capsule orally every 12 hours. There is no notation concerning any rationale for the Kadian® (morphine sulfate) and/or any discussion with patient S.B. concerning the new medication. Respondent ordered X-rays of the lumbosacral area of the spine (4 views). Respondent also refilled patient S.B.’s prescriptions for Soma® (carisoprodol) 350 mg, #100, one tablet tid (three times-a-day); Vicodin ES® (hydrocodone/acetaminophen) 75 mg/750 mg tablet, #60, one-half to one tablet (two times-a-day as needed); and Xanax (alprazolam) 1 mg, #90, tid prn (three times-a-day as needed).

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7 Kadian® (morphine sulfate) is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.
12. On or about January 11, 2012, patient S.B. was seen by another physician Dr. C.T., for her chief complaint of chronic obstructive pulmonary disease (COPD) which was progressively worsening and was of moderate intensity. The respiratory review of symptoms was “[p]ositive for chronic cough and dyspnea (shortness of breath) [and] [n]egative for hemoptysis or pleuritic chest pain.” The respiratory exam noted, among other things, “decreased breath sounds.” Patient S.B. was given an intramuscular (IM) injection of Depo Medrol (a long acting anti-inflammatory steroid) and she was prescribed Zithromax® (azithromycin dihydrate), 8 200 mg, #6, with directions to take 2 tablets on day one; and 1 tablet daily for the next 4 days.

13. On or about January 16, 2012, patient S.B. was seen again by Dr. C.T., for a chief complaint of abdominal pain. The respiratory review of symptoms notes “[p]ositive for chronic cough, dyspnea and frequent wheezing” and the gastrointestinal review of symptoms notes “[p]ositive for abdominal bloating and nausea.” The respiratory exam notations in the medical record indicate “normal breath sounds with no rales, rhonchi, wheezes or rubs” and the gastrointestinal exam was noted as “no masses palpated; distended; moderate L.I.Q (left lower quadrant) pain.” The assessment was “[g]eneralized abdominal pain” with a recommendation that patient S.B. “go to ER [emergency room].”

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8 Zithromax® (azithromycin dihydrate) is an antibacterial drug used to treat mild to moderate infections, and is a dangerous drug pursuant to Business and Professions Code section 4022.
14. On or about January 27, 2012, patient S.B. had her fifth visit with respondent. Her chief complaint was listed as “GI GERD (gastroesophageal reflux disease).” The medical record for this visit contains no notations regarding the status of patient S.B.’s abdominal pain, whether or not she went to the emergency room, and what, if any, treatment and/or studies were done. The respiratory review of symptoms states “[n]egative for chronic cough, dyspnea and frequent wheezing” and the gastrointestinal review of symptoms states “[n]egative for constipation and diarrhea.” The gastrointestinal physical examination for this visit states “normal bowel sounds; moderate epigastric pain; no organomegaly (enlarged intra-abdominal organs).” The assessment is listed as “[g]astroesophageal reflux disease.” As part of this visit, respondent recommended Zantac® (ranitidine),\(^9\) 150 mg, #60, 1 tablet orally bid (twice-a-day); recommended Simethicone,\(^10\) 80 mg, #60, 1 chewable tablet orally bid (twice-a-day); and prescribed Methadone Hydrochloride (methadone)\(^11\) 10 mg, #60, 1 tablet bid (twice-a-day). There was no mention in the medical record of the rationale for the new prescription of methadone, no indication of any discussion with the patient about the methadone, and no indication of advising patient S.B. to stop taking the Kadian® (morphine sulfate) that had previously been prescribed by respondent on or about December 30, 2011. As part of this visit, respondent also provided a refill to patient S.B. for Xanax (alprazolam) 1 mg, #90, tid prn (three times-a-day as needed).

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\(^9\) Zantac® (ranitidine) is typically used to treat heartburn and indigestion.

\(^10\) Simethicone is typically used to treat heartburn and indigestion.

\(^11\) Methadone Hydrochloride may be indicated for the treatment of moderate to severe pain responsive to non-narcotic analgesics or for detoxification or maintenance treatment of opioid addicted patients in conjunction with appropriate social and medical services. Methadone Hydrochloride is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.
15. On or about February 21, 2012, patient S.B. had her sixth and final visit with respondent. The medical record for this visit indicates “[m]edical problems to be addressed today include DDD (degenerative disc disease).” The history of present illness (HPI) and review of systems (ROS) for this visit are identical to the visit on or about December 30, 2011, and appear to be a “cut and paste” from the prior medical record for on or about December 30, 2011. The current medication list for this visit indicates, among various other medications, methadone, and the previous prescription of Kadian® (morphine sulfate) is deleted from the list of current medications. However, under the “Plan” section of the medical record for “Degeneration of Lumbar disc” there is a prescription refill indicated for Kadian® (morphine sulfate), 1 mg, #90, with directions to take 1 tablet orally tid prn (three times-a-day as needed).

4. Approximately seven months before Respondent began seeing S.B., the clinic installed a new electronic medical record keeping system bearing the brand name EMD. The physicians at the clinic were requested to use the new system in order to comply with the requirements of the Affordable Care Act. Respondent agreed to use the new system, but he was unfamiliar with electronic medical record keeping, and he was provided with little training on the system. As a result, he was required to learn the system largely as he went along through informal discussions with his colleagues and through trial and error.

5. By the time of S.B.’s first visit, Respondent was still struggling with the system. He did not know how to change critical entries from the patient’s prior visits, such as the chief complaint, review of systems, and assessment. His requests for additional training went unanswered. Therefore, Respondent allowed S.B.’s records to reflect inaccurate information. However, Respondent was aware of how to enter “free text” (i.e. his own entries using his own words) in the area designated as History of Present Illness (HPI). Although Respondent could have written caveats into the system that certain entries were inaccurate or the reasons for medication changes, he chose not to do so, opting to submit untrue medical records over his electronic signature instead of inconsistent records that alerted the reader to the inaccuracies in the record and providing the reader with the accurate information, albeit in a different section of the chart. By signing the records, Respondent attested to their accuracy.

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12 Respondent testified that the Chief Complaint section came to him either pre-populated, or completed by his medical assistant. Either way, he was unable to change it.
6. When faced with his inability to enter pertinent information into the electronic record, Respondent did not make any attempt to return to paper charting with which he was more comfortable, and he did not otherwise attempt to alert subsequent providers or others who might rely on the medical records that the records were inaccurate at best, and at worst, simply untrue.

7. One of the inaccuracies that was repeated several times in the electronic record was that S.B. had a painful tongue. Because that entry was untrue, Respondent did not examine her mouth or tongue on any of the six visits. However, in an October 24, 2012 letter, and in an interview with Board personnel on June 27, 2013, Respondent stated that, on at least one visit, S.B. presented with a painful tongue. Respondent testified that he did not have a clear recollection of the patient when he wrote the letter and discussed the patient at the interview. Those errors illustrate the importance of maintaining adequate and accurate records.

8. Warren B. Churg, M.D. served as Complainant’s expert witness. Dr. Churg received his Bachelor’s degree at Columbia University in New York, his medical doctorate at Johns Hopkins University School of Medicine in Baltimore, and he served his internship and residency in internal medicine at Cedars Sinai Medical Center in Los Angeles. He then served a fellowship in adolescent medicine at Children’s Hospital of Los Angeles. He is the Associate Director of Inpatient Training in the Family Practice Residency Program of Glendale Adventist Medical Center where he is also an attending physician and where he has also served as Chief of Staff and Associate Medical Director. He is also the Medical Director of the hospital’s Alcohol and Drug Services. Dr. Churg has taught medical students and residents at Loma Linda University for 34 years and at the University of Southern California for 28 years.

9. Dr. Churg credibly and convincingly opined that Respondent committed a simple departure from the standard of care with respect to medical record keeping in outpatient primary care. In his report, Dr. Churg explained:

Each medical record entry should reflect a clear reason for that day’s visit, an updated description of the patient’s history, physical findings, laboratory and radiology results if applicable, an assessment of the patient’s current status, a clear A/P section (assessment and plan) and an accurate list of current and new medication. There should be at least a brief summation of the rationale for changing, adding or deleting, either treatments or medications. The record should be clear enough so that not only the same continuity physician, but any new or interim provider, can easily ascertain the current status of the patient, link treatments to particular therapies or medications, and understand the reason behind any changes.

(Exhibit 7, page AGO-752.)
10. Dr. Churg credibly and convincingly opined that Respondent committed a simple departure from the standard of care with respect to monitoring a patient on long term opiates or other controlled substances to attempt to discover abuse or diversion. He wrote:

Strategies to prevent or deduce the risk of opiate misuse, abuse, or diversion include insisting that the patient obtain prescriptions from only one physician or practice, the use of only one pharmacy, periodic drug testing to look for the presence of the actual prescribed medications and the possible presence of non prescribed or illicit substances, and pill counting, i.e. asking the patient to bring in their pill bottles and verify the amounts remaining. Use of CURES\(^{13}\) reports by both physicians and pharmacies is very helpful. Setting firm goals with the patient and at times using a formal agreement or contract are additional potentially useful practices. Warning signs of potential misuse are frequent “lost” or stolen prescriptions, repeated requests for early refills, use of another patient’s medications, “doctor shopping”, arrests or police involvement, use of multiple pharmacies, signs of excessive sedation, dizziness, confusion, aberrant behaviors, and upon evaluation a determination that there is no apparent consistent underlying anatomic or physiologic process consistent with the reported degree of pain. Some groups are statistically more likely to abuse controlled substances, i.e. younger patients, patients with co-morbid psychiatric diseases[,] a history of drug or alcohol abuse, or an unstable social or employment environment.

Clear charting in the medical record of complaints and changes in health conditions, physical exam, laboratory and imaging studies, referrals to other specialists, exact dosages and amounts of medications prescribed are necessary for optimum continued care by the primary prescribing physician as well as any other health care practitioners involved in a patient’s overall care.

(Id. at AGO-754-755.)

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\(^{13}\) CURES is the Controlled Substance Utilization Review and Evaluation System operated by the California Department of Justice.
11. At the hearing, Dr. Churg pointed out a number of ways in which Respondent committed simple departures from the standard of care and engaged in a practice of inadequate and inaccurate record keeping. For example, Respondent failed to address the alleged complaints of painful tongue. He failed to specify whether the Vicodin prescription was a standing order or as needed. He failed to document a history or physical examination for fibromyalgia. He failed to document the rationale for changing medications. He failed to document a diagnosis of infection at the time he prescribed Keflex. He failed to specify a list of benefits and alternatives when he prescribed Kadian. He failed to document whether the patient had gone to the emergency room as another physician had recommended and, if so, the results of the emergency room visit. He failed to document the patient’s informed consent for methadone, and he failed to link the patient’s level of pain to the condition being treated.

12. Dr. Churg convincingly opined that the standard of care for adequate and accurate records is the same regardless of whether the records are handwritten or electronic.

13. Ayad M. Gharghouri, M.D. served as Respondent’s expert witness. Dr. Gharghouri received a Bachelor of Science degree in pharmacy from St. John’s University in Jamaica, New York and his medical doctorate from the University of Noreste School of Medicine in Tampico, Mexico. He served his internship and residency in combined medicine and pediatrics at the University of Medicine & Dentistry of New Jersey in Newark, New Jersey, and a fellowship in pulmonary and critical care at California Pacific Medical Center in San Francisco. Dr. Gharghouri has been in private practice since 1994 specializing in pulmonary and internal medicine. He is a former Chief of Staff at Hi-Desert Regional Medical Center. He is currently the Chair of the hospital’s Governing Board and a member of its Medical Executive Committee. He is both a professional colleague of, and a subordinate to, Respondent, who is the hospital’s current chief of staff.

14. Dr. Gharghouri had owned and operated an EMD system in his private office for many years before the clinic’s system was installed. He was instrumental in the decision to install the same system in the clinic. Although he was very comfortable with all of the system’s options and was able to use the electronic system with as much ease and flexibility as paper charts, he claimed that upgrades and changes in the system “can be quite painful” and that, because vendors do not like to come to the high desert to offer training, physicians learning the system must rely on telephone and Internet support.\(^{14}\)

\(^{14}\) Dr. Gharghouri had, and continues to have a contracted agent for technical support with the system. His staff contacts the agent whenever a problem occurs that they are unable to remedy.
15. Dr. Gharghoury testified that Respondent did not deviate from the standard of care because primary care physicians in a rural setting such as the one in which he and Respondent work see several patients per day and do not have the time to document their charts in the same manner as pain management specialists working in an urban environment. However, by reading Respondent’s electronic medical records, one can infer all of the information necessary even if it is not specifically written. Dr. Gharghoury explained: “You can’t put it all in writing. Some of it has to be inferred.”

16. Dr. Gharghoury does not believe it was necessary to get the patient’s informed consent for methadone because methadone belongs to the same family of drugs as Vicodin and Kadian. Further, it was unnecessary for Respondent to specify why he added Kadian to S.B.’s pain medications. Kadian is a long-acting narcotic analgesic. Vicodin is short-acting. In Dr. Gharghoury’s terms, the reason for adding Kadian was “obvious.” However, he conceded that “ideally” (Dr. Gharghoury’s term) there should have been an explanation why Respondent changed S.B.’s medication from Kadian to Methadone and later back to Kadian. Similarly, “ideally,” Respondent should have documented whether S.B. went to the emergency room and, if so, what had occurred there. However, Dr. Gharghoury believes that the emergency room physician would have contacted Respondent had something “catastrophic” occurred.

17. Dr. Gharghoury acknowledged the difficulty Respondent had in learning how to work the EMD system and opined that “[y]ou do the best you can with what you have.” He testified that Respondent could have written something by hand or alerted subsequent providers to the inaccuracies of the records in some other way, but dismissed that notion as “Monday Morning Quarterbacking.”

18. Dr. Gharghoury defined the standard of care as that which a reasonable physician would do under the circumstances. He did not base his opinions on any of the literature or other documents. However, he found that S.B. did not suffer any harm from anything Respondent did or did not do, and that “[t]he cardinal principle of medical practice, ‘DO NO HARM’ was never violated.” (Dr. Gharghoury’s report, Exhibit E, page 4. Emphasis in text.) Dr. Gharghoury concluded:

In closing, when all the above facts have been considered, I do not believe that any act or alleged inaction on the part of Dr. Mahajan in the care of this patient represents any departure from the standard of care. I know Dr. Mahajan as a fellow internist. He has a reputation of being very dedicated, compassionate, and skilled. He would not have been otherwise elected as our Chief of Staff at Hi-Desert Medical Center.”

(Ibid.)

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19. Based on their experience, the apparent bias of Dr. Gharghoury as demonstrated in Factual Finding 18, above, and Dr. Chun's sound reasoning, the report and testimony of Dr. Chun were more convincing than those of Dr. Gharghoury.

20. Between October 26 and October 30, 2015, Respondent took and completed the Physician Prescribing Course and the Medical Record Keeping Course offered by the University of California, San Diego, Physician Assessment and Clinical Education Program (PACE). Although taking the courses provides evidence of some rehabilitation, the timing of the courses is suspect, coming approximately one and one-half weeks before the administrative hearing. Respondent was aware of the patient's complaint against him no later than October 24, 2012, when he wrote a statement addressed to the Board concerning his care and treatment of S.B., and he was aware of allegations of poor record keeping no later than June 27, 2013, when he was interviewed by Board personnel. Further, since his entire defense is based on the lack of training on the electronic medical record keeping system, one would expect that Respondent might have taken matters into his own hands in 2011 or 2012 and taken the Medical Record Keeping course at that time in order to avoid making false statements in his patients' medical records.

21. Nonetheless, Respondent has improved his electronic record keeping skills to the point that he is able to document the records in a manner similar to that in his handwritten records.

22. Nigist Asfaha, M.D. wrote a letter on Respondent's behalf. She described Respondent as a "very conscientious physician" who "maintains the highest standards of Medicine." (Exhibit B.) Describing a shortage of pain management specialists in the high desert area, she commended Respondent and his colleagues for their management of chronically narcotic dependent patients.

LEGAL CONCLUSIONS

1. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), for repeated negligent acts, as set forth in Findings 3 through 19.

2. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, as defined by section 2266, for failure to maintain adequate and accurate records, as set forth in Findings 3 through 19.

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15 According to her letter, Dr. Asfaha practices pain management in that geographic area.
3. The parties do not dispute that S.B.’s records were inaccurate for the six visits she had with Respondent. The question is whether the standard of care permits false or inaccurate records when the record keeper is so unfamiliar with the record keeping system that he or she either cannot make the records true and accurate or fails to take other steps to alert subsequent providers of the records’ falsity or inaccuracy.

4. The question was persuasively answered by Dr. Churg in the manner referenced in the factual findings, above. Dr. Gharghoury’s testimony provided mitigation to a certain extent, but did not constitute a complete defense of Respondent’s conduct. Further, Dr. Gharghoury demonstrated a bias in favor of Respondent as was evidenced not only in their close professional association, but also in Dr. Gharghoury’s report which combined the elements of both an expert witness report and a character reference. (Exhibit E.)

5. An inability to correctly operate an electronic medical record keeping system does not relieve a physician of his/her responsibility and obligation to maintain adequate and accurate records. In this case, Respondent could have alerted a subsequent provider or other individual who was required to rely on S.B.’s medical records for accurate information about her medical history and condition in at least two ways. He either could have placed the accurate information in the HPI section of the chart, where he was able to free text, or he could have maintained independent paper records documenting the portions of the electronic chart that were inaccurate.

6. Although Dr. Gharghoury may have been correct that a skilled physician could infer certain facts from Respondent’s inaccurate records, a subsequent provider should not have to infer anything from a medical record. One of the purposes of adequate and accurate record keeping is to take the guesswork, or even inferences, out of quality patient care.

7. Both Dr. Gharghoury in his report and testimony, and Respondent’s counsel in closing argument, pointed out the fact that no patients were harmed by Respondents acts or omissions. Actual injury or harm to a patient is not necessary for disciplinary action to be taken against a licensee. (Kearly v. Board of Medical Quality Assurance (1986) 189 Cal.App.3d 1040, 1053.) This is especially true in a case such as this where a patient’s false or inaccurate medical records could have an adverse effect on her at some time in the future, such as when incorrectly acted upon by a subsequent physician providing care and treatment in ignorance of Respondent’s wrongdoing, or an insurance carrier considering whether to afford life or health coverage to the patient based on her medical history, or by any other individual who relies on the medical records to make decisions important to the patient’s future. It is troubling that Respondent knowingly permitted those records to stand uncorrected and over his signature which attested to their accuracy even after he learned how to use the system more effectively, and without asking his medical assistant for help. By so doing, he placed the clinic’s interests above those of his patient by intentionally creating false electronic medical records without correction so that the clinic could comply with the Affordable Care Act.

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8. Negligence “may be attributable to remissness in discharging known duties, rather than . . . incompetency respecting the proper performance.” (Peters v. Southern Pacific Co. (1911) 160 Cal. 48, 62.) Respondent knew and understood the importance of accurate medical records and his duty to ensure the accuracy of his patients’ medical records. He was negligent in discharging that duty.

9. By S.B.’s fourth visit (December 30, 2011), Respondent was apparently facile enough with the EMD system to change the Chief Complaint section of the electronic record. However, he did not return to his documentation of S.B.’s three earlier visits to make late entries correcting the chart. As referenced in footnote 12, above, Respondent testified at the administrative hearing that it may have been his medical assistant who made the Chief Complaint entries. However, he did not enlist the medical assistant’s aid in correcting S.B.’s records.

10. It also appears that, on the December 30, 2011 visit, Respondent was able to correctly document his physical examination and the change in dosage of the Vicodin ES. Yet, on February 21, 2012, S.B.’s final visit, much of the prior “copy and paste” language remained.

11. Respondent was intentionally dishonest when he attested to false medical records, but that dishonesty was borne of ignorance rather than malice. He did not so act for personal gain or on behalf of another who stood to gain from the false records other than to the extent that his use of the electronic medical record keeping system engendered the clinic’s compliance with the Affordable Care Act. He was simply unable to correct inaccuracies in the records and chose to allow them to stand rather than take other steps to alert others to the inaccuracies. Since that time, Respondent has improved his electronic record keeping to an acceptable level and, perhaps in a dilatory fashion, he completed the PACE prescribing and medical record keeping courses.

12. As referenced above, Respondent’s knowing dishonesty with respect to the false medical records is troubling and would justify placing Respondent on probation for a period of time had dishonest acts been alleged as a cause for discipline. However, that cause for discipline was not alleged. Therefore, a public letter of reprimand shall be issued by the Board. Among other requirements, Respondent shall be required to repeat the prescribing and medical record keeping courses unless the Board finds his recent completion of those courses sufficient to satisfy those requirements. Respondent shall also be required to complete an ethics course to address the dishonesty issues raised during the hearing.

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ORDER

A Public Letter of Reprimand shall issue from the Board, under the provisions of Business and Professions Code section 2227, subdivision (a)(4), to Respondent Sumit Mahajan, Physician’s and Surgeon’s Certificate number A 80732, with the following requirements:

1. Education Course

Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours duration. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent’s expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent’s knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

Respondent’s failure to comply with this provision may be construed by the Board as unprofessional conduct.

2. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after Respondent’s initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The prescribing practices course shall be at Respondent’s expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted toward the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.
Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

Respondent’s failure to comply with this provision may be construed by the Board as unprofessional conduct.

3. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after Respondent’s initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at Respondent’s expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

Respondent’s failure to comply with this provision may be construed by the Board as unprofessional conduct.
4. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six months after Respondent’s initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one year after attending the classroom component. The professionalism program shall be at Respondent’s expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

Respondent’s failure to comply with this provision may be construed by the Board as unprofessional conduct.

Dated: November 19, 2015

[Signature]

H. Stuart Waxman
Administrator of Law Judge
Office of Administrative Hearings