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

In the Matter of the Accusation Against:	)	
DAYALAL D. TANK, M.D.	)	**Case No. 11-2010-207184**
Physician's and Surgeon's Certificate No. A 53624	)	
Petitioner	)	

DECISION AND ORDER

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 8, 2014.

IT IS SO ORDERED July 9, 2014.

MEDICAL BOARD OF CALIFORNIA

By: Dev Gnanadev MD
Dev Gnanadev, M.D., Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
DAYALAL D. TANK, M.D.,	Case Nos. 11-2010-207184
Physician's and Surgeon's Certificate Number A 53624	OAH Case No. 2013100663
Respondent.	

PROPOSED DECISION

This matter came before Samuel D. Reyes, Administrative Law Judge, Office of Administrative Hearings, in San Diego, California, on March 11, 12, 13, and 14, 2014, and in Los Angeles, California, on March 17 and 18, and May 27, 2014.

Claudia Ramirez, Deputy Attorney General, represented complainant Kimberly Kirchmeyer, Interim Executive Director of the Medical Board of California (Board).

Benjamin Fenton, Attorney at Law, represented Dayalal D. Tank, M.D. (Respondent).

Complainant seeks to discipline Respondent's medical license on grounds of alleged incompetence. Respondent denies the allegations and asserts that cause for discipline does not exist.

Oral and documentary evidence, and evidence by oral stipulation on the record, was received at the hearing, and the matter was submitted for decision.

FACTUAL FINDINGS

Parties and Jurisdiction

1. Complainant filed the Accusation on October 10, 2013, in her official capacity.

2. a. On October 12, 1994, the Board issued Physician's and Surgeon's Certificate Number A 53624 to Respondent. The certificate has been in effect since then and was due to expire on May 31, 2014, unless renewed. The certificate has not been previously disciplined.

b. On October 2, 2013, Office of Administrative Hearings Administrative Law Judge David B. Rosenman issued an Order Granting Petition for Order of Interim Suspension (ISO) suspending Respondent's Physician's and Surgeon's Certificate pending the outcome of proceedings to discipline the certificate. In issuing the ISO, Judge Rosenman concluded that there was a reasonable probability that Complainant would prevail in the underlying action to discipline the certificate and that the likelihood of injury to the public in not issuing the ISO outweighed the likelihood of injury to Respondent in issuing it.

3. Respondent received his medical degree from the M.P. Shah Medical College in Jamnagar, India, in 1976. In 1990, he migrated to the United States, and in 1992, he passed the Federal Licensure Examination (FLEX) examination, the predecessor to the United States Medical Licensing Examination (USMLE), to practice medicine in the United States. In July 1997, he completed a four-year general psychiatry residency at Charles Drew University of Medicine and Science/Martin Luther King Jr. Medical Center in Los Angeles, California.

4. Respondent has been engaged in the practice of general psychiatry in Southern California area since completing his medical training. From September 1997 until his license was suspended, Respondent primarily worked at the Sunset Psychiatric Medical Center in West Covina, California, although he has worked part-time in several clinics and hospitals over the years. He was also on the staff of the Citrus Valley Medical Center (Citrus Valley), from December 4, 1997 to March 1, 2010, and on the staff of the Aurora Behavioral Health Care/Charter Oak (Aurora), from February 18, 1999 through January 24, 2011. As a staff member of Citrus Valley, Respondent was on call every four to five days, and saw four or five patients each time. He typically saw 10 to 15 patients per day outside of the hospital.

Physician Assessment and Clinical Education (PACE) Program

5. University of California, San Diego (UCSD), School of Medicine faculty administer the PACE Program, and have designed it to test physician competency. The program seeks to measure the six core competencies developed by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties, namely, patient care, medical knowledge, practice-based learning and improvement, communication and interpersonal skills, professionalism, and systems-based practice. PACE consists of two phases conducted on two separate dates, and it is primarily focused on the physician's area of practice.

6. During Phase I, which typically lasts two days, participants provide information about themselves in self-reporting instruments; they undergo physical and mental evaluation, which includes a cognitive screening test, the Microcog; they complete a history and physical examination on a mock patient; they participate in an oral clinical examination; they provide a random sample of charts for review; they review cases presented through the computerized program PRIMUM; they undergo a Transaction Simulated Recall (TSR) interview based on the cases presented in PRIMUM; they take multiple choice examinations created by the National Board of Medical Examiners (NBME) and complete other written tests; and they participate in an exit interview, usually conducted by William A. Norcross, M.D. (Norcross), the Director of the PACE Program.

7. In Phase II, which typically lasts five days, participants are assessed in a clinical environment at the UCSD Medical Center or at one of its clinics. Specifics vary depending on the participant's specialty. They are typically provided some instruction, participate in patient treatment rounds, and treat "standardized" patients, i.e., mock patients who have been instructed regarding the type of condition(s) they pretend to have.

8. Each participant in the PACE program is assigned a case manager, a staff member responsible for coordinating the participants' activities and for gathering and maintaining information. Faculty involved in the assessment process prepare reports to document their observations, and submit them to the case manager.

9. At the conclusion of Phase I and again at the conclusion of the entire program, Dr. Norcross and other involved doctors and staff meet in a case conference to determine the next step. At the conclusion of Phase I, the determination involves whether there are any issues, such as mental or physical competence, that would preclude completion of the program. At the end of Phase II, the team makes a decision on the physician's ability to safely engage in the practice of medicine. There are three possible "grades" or outcomes: "pass," which signifies a good to excellent performance in most or all areas measured and is consistent with safe practice and competency with no significant deficiencies noted; "pass with recommendations," in which deficiencies are found, either minor or significant, and where recommendations for remediation are made; and "fail," which signifies poor performance not compatible with overall physician competency and safe practice. A report is then prepared summarizing the participant's performance and the PACE Program's conclusions.

Respondent's First Time in the PACE Program

10. In February 2009, Citrus Valley initiated a peer review process of Respondent's practice due to concerns about his high rate of patient readmission and his dictation of progress notes. Respondent agreed to successfully complete the PACE Program to resolve the pending concerns.

11. Respondent participated in Phase I of the PACE Program on May 11 and 12, 2009. Sheila Pickwell, M.D. (Pickwell), conducted a physical examination of Respondent and found no health conditions or abnormalities that would prevent Respondent from safely practicing medicine.

12. Respondent was administered the Microcog, a computer-based screening test of cognitive skills that is used to determine if a participant warrants additional neuropsychological evaluation. A participant's scores is compared to two groups, one of those with similar age and education, in Respondent's case those aged between 55 and 64 with more than a high school education, and one group of all ages and education levels. With respect to the group in his age and education bracket, Respondent scored in the average range in all areas measured, except for reaction time, where Respondent scored in the low average range (10th percentile). When the comparison group was that of participants of all ages, Respondent's scores fell to below average in the reaction time measurement (1st percentile) and to low average in the general cognitive

functioning (10th percentile), general cognitive proficiency (14th percentile), information processing accuracy (12th percentile), attention/mental control (12th percentile), and memory (10th percentile) categories. PACE physicians concluded that further neurological evaluation was not warranted.

13. Dr. Pickwell evaluated Respondent's performance in taking a history and conducting a physical exam of a mock patient. She concluded that the examination was substandard, as Respondent failed to obtain a complete health history or conduct a satisfactory physical examination.

14. Mounir Soliman, M.D. (Soliman), Associate Clinical Professor of Psychiatry, UCSD, performed a one-hour oral clinical examination. Dr. Soliman presented cases to Respondent and asked questions to assess Respondent's clinical skills. Dr. Soliman concluded that Respondent failed to achieve a passing score of 70 percent in two of the three areas tested, case formulation (65 percent) and derivation of diagnosis (68 percent). With respect to the former, Dr. Soliman noted that Respondent was not able to integrate available information related to the case to explain the psychiatric presentation based on the biological, psychological, and social aspects. Regarding the latter, Respondent missed multiple diagnoses, such as post traumatic stress disorder (PTSD), substance induced mood disorder, and borderline personality disorder, and was not familiar with the diagnostic criteria for schizoaffective disorder. Respondent attained a passing score in the treatment plan area, despite needing some help with medication side effects.

15. Dr. Soliman examined a random sample of Respondent's charts, and found illegible handwriting in some of them and concluded that the charts often lacked pertinent information.

16. Respondent completed the Behavioral Health Care version of the PRIMUM computerized test. Respondent was asked to assess eight cases, and obtained below-average scores compared to a group of third-year residents. At the conclusion of the computer case simulations, a record of Respondent's actions, called a "transaction list," was produced, and Dr. Pickwell conducted the TSR, or a discussion with Respondent about his reported actions, to gain a better understanding of his thinking process during the computer simulation. Dr. Pickwell noted that Respondent diagnosed three of the cases correctly, but his assessment and management was incomplete in each of the eight cases.

17. Respondent completed four written multiple choice examinations designed by the NBME and scored in the following percentiles: (1) Ethics and Communication (1st percentile, or lower than 99 percent of the control group of 2,000 physicians who were taking the USMLE Step 3 exam for the first time); (2) Pharmacotherapeutics with Behavioral Health Focus (1st percentile); (3) Mechanisms of Disease (3rd percentile); and (4) Psychiatry Clinical Science Subject Exam (2nd percentile).

18. During Phase II, which took place on October 19 through 23, 2009, Respondent spent time at the UCSD Department of Psychiatry and the clinics it supervises under the overall

supervision of Dr. Soliman. He received instruction, interacted with faculty members, and underwent assessment by them. As reported by Dr. Soliman, Respondent participated in an introductory session, psychopharmacology supervision and didactic sessions, and adult outpatient treatment rounds and geropsychiatry rounds. Respondent completed selected readings on psychopharmacology and psychopathology, and reviewed computer presentations on attention deficit hyperactivity disorder, depression, schizophrenia and addiction. Staff who interacted with Respondent had positive comments about his appearance, communication skills and participation. A faculty member thought he missed a differential diagnosis, and found his analysis logical, but rather simple, missing some of psychosocial nuances of the case. Similarly, another evaluator concluded that Respondent was not able to integrate available information related to a case to explain the psychiatric presentation based on biological, psychological and social aspects. Another person felt that Respondent was able to discuss a case better than he was able to document it, and emphasized the importance of documentation. Respondent achieved an 85 percent score in the final psychopharmacology examination.

19. The PACE case review group concluded that Respondent's performance in Phases I and II had been substandard. There were deficiencies in diagnosis, documentation, information integration and symptom explanation, case formulation, attendance to psychosocial aspects, medical knowledge, and communication. The November 23, 2009 report stated: "[B]ased on the results of both Phase I and Phase II, [Respondent]'s medical knowledge deficit appears to be broad-based (with the possible exception of psychopharmacology). In addition[,] his medical record keeping and communication skills are severely limiting. The PACE Program feels that he is not currently safe to practice psychiatry and would require significant updating and re-evaluation if he were to attempt to return to practice." (Exh. 5, at p. 6.)

20. At the hearing, Respondent explained that psychiatrists do not typically conduct physical examinations and that he had never conducted one in his practice. The NBME tests had many subjects residents are required to study, such as neurology, emergency medicine, and obstetrics/gynecology, which are not encountered by practicing psychiatrists. The five-day Phase II program was confusing to him about what he needed to do. He did not treat patients, and only observed others. He was given materials to read, and was sometimes asked questions.

Board Investigation

21. Citrus Valley had given Respondent a one-year leave of absence to complete the PACE Program. Respondent did not renew his privileges at Citrus Valley at the conclusion of the year. On May 10, 2010, Citrus Valley filed a report with the Board, as required by Business and Professions Code section 805. Citrus Valley reported Respondent's participation in PACE and stated that Respondent's privileges had been terminated upon the expiration of the one-year leave of absence and his failure to request reinstatement.

22. Aurora commenced its own investigation following action by Citrus Valley. After the Aurora investigation commenced, a physician who used to cover Respondent's patients in his absence declined to provide such coverage. Aurora suspended Respondent's privileges until he obtained coverage. Respondent did not renew his privileges. On February 28,

2011, Aurora reported to the Board; "[Respondent] did not renew his medical staff membership at [Aurora] while on automatic suspension based upon his failure to designate an alternate. At the time that [Respondent] chose not to renew his member ship [*sic*], he was under investigation by the Medical Executive Committee based upon patient care concerns." (Exh. 44, at p. 2.)

23. The Board commenced an investigation following the filing of the reports by Citrus Valley and Aurora, which investigation included interviewing Respondent and reviewing PACE records. The matter was referred to the Attorney General's Office for the filing of an accusation, and the case was thereafter resolved by Respondent's agreement to successfully complete the PACE Program.

Respondent's Second Time in the PACE Program

24. While there was some repetition of prior assessment tools, Dr. Norcross and the PACE Program sought to make the reassessment as fair and relevant as possible by changing a few things. Some of the participating faculty members were changed, Respondent did not have to perform a mock physical examination, and the number of NBME tests was reduced. Respondent participated in Phase I on January 17 and 18, 2013. Dr. Pickwell again conducted a physical examination of Respondent and found no health conditions or abnormalities that would prevent Respondent from safely practicing medicine.

25. a. Respondent underwent a second Microcog screening test as part of Phase I. Respondent's scores were lower than those he obtained in the 2009 Microcog with respect to both comparison groups. Relative to a person of similar age and educational background (aged between 55 and 64 with more than a high school education), Respondent performed in the low average range on four categories: general cognitive functioning (8th percentile), general cognitive proficiency (4th percentile), information processing speed (3rd percentile), and reasoning/calculation (3rd percentile). In 2009, he had scored in the low average in only one category, reaction time. He scored in the average range on information processing accuracy (30th percentile), attention/mental control (58th percentile), memory (25th percentile), spatial processing (19th percentile), and reaction time (30th percentile).

b. When compared to a control group regardless of age, the results were even lower. Results dropped to below average in the information processing speed (1st percentile) and reaction time (1st percentile) categories. The results were in the low average range in the following five categories: general cognitive functioning (2nd percentile), general cognitive proficiency (3rd percentile), reasoning/calculation (3rd percentile), memory (6th percentile), and spatial processing (3rd percentile). Respondent scored in the average range only on information processing accuracy (21st percentile) and attention/mental control (39th percentile).

c. At some undetermined time after 2009, PACE changed the manner in which it reviewed the Microcog results. Instead of relying on Dr. Norcross and the other case review physicians, the Program started utilizing the services of neuropsychologist William Perry, Ph.D. (Perry), a UCSD faculty member who is an expert on the Microcog. Dr. Perry

reviewed the scores obtained by Respondent and concluded that they were low enough to warrant further assessment.[1]

d. Dr. Perry opined that Respondent had scored very low in many areas of brain functioning and further neuropsychological evaluation was indicated. The data suggested a person who would have problems handling complex information efficiently. The actual scores were of particular concern, since "average" was broadly defined to include two standard deviations from the mean instead of one, and referring to a score as "low average" may actually underestimate Respondent's deficits. Dr. Perry would have expected that someone of Respondent's education and experience to have scored much higher absent cognitive problems.

e. Dr. Perry conceded that the test-taker's ethnicity and primary language could impact the results, but such fact did not alter his opinion because Respondent had scored low in nonverbal subtests less impacted by cultural factors.

26. a. Also as part of Phase II, Respondent obtained a psychiatric history and performed a mental status examination on a mock 29-year-old female patient. While participants are given 45 to 50 minutes to complete the examination, Respondent completed it in 35 minutes. He spent approximately 20 minutes writing a progress note (he declined the option to type the note on a computer). Margaret E. McCahill, M.D. (McCahill), Clinical Professor of Family Medicine and Psychiatry, evaluated Respondent's performance.

b. Respondent conducted himself in a professional manner and his affect was professional. In Dr. McCahill's view, Respondent seemed to have difficulty understanding the English-speaking patient and the patient had difficulty understanding Respondent. Respondent started by inquiring about most of the major categories of mental illness, but most inquiries were brief. For instance, he asked if she had depression and, upon obtaining a negative response, Respondent only asked a few follow-up questions based on the symptoms of depression before moving on to another category.

c. Dr. McCahill expressed concern about Respondent's "cognitive abilities" on the basis of two events. At the start of the visit, Respondent talked to the patient about her 10-month-old son, but approximately 15 minutes into the session, he asked her if she had any children. As part of the mental status examination, Respondent asked the patient to remember three objects, but did not test her recollection by asking about the three objects later in the session. In the note, Respondent wrote that the patient's memory was "intact" without reference to the 3-object test.

d. Respondent did an adequate job covering the patient's substance use history and past medical history and a good job inquiring about the patient's family history, legal history, social history, educational history, and occupational history. He did not seem to know what "lap band surgery" or "Planned Parenthood" were.

---

[1] Dr. Perry opined that the results in the 2009 Microcog similarly indicated that further evaluation was warranted.

e. Respondent came to the correct diagnostic conclusion, insomnia, and did not, in Dr. McCahill's opinion, "over-pathologize" the patient's complaint. However, in explaining his impression to the patient, Respondent provided very limited patient education and none about non-medication steps. In discussing the possible risks of potential medications, sleep aids Ambien and Lunesta, Respondent only briefly mentioned the possibilities of dependence and sleep-walking, which Dr. McCahill deemed inadequate to obtain informed consent.

27. a. Sanjai Rao, M.D. (Rao), Assistant Clinical Professor of Psychiatry, performed a one-hour oral clinical examination. Dr. Rao performed a modified oral specialty-boards-style exam using the hypothetical case of a 34-year-old male with mood, anxiety, and PTSD symptoms who presented with a chief complaint of lack of motivation. After giving Respondent the chief complaint in the case, Dr. Rao instructed Respondent to ask for pertinent history and then to formulate the case and present a treatment course.

b. In Dr. Rao's opinion, Respondent was able to elicit an acceptable history, albeit with some deficiencies. For instance, for the history of present illness, Respondent obtained a good history of depressive symptoms, including a basic screen for suicidal ideation, but did not ask whether the patient had a suicide plan or intent. He did not initially screen for mania or anxiety, but did so during the differential diagnosis when he apparently realized that he had missed these elements. He obtained an acceptable past psychiatric history, but could have added detail. He obtained a basic family history of prior diagnoses, but did not ask about prior treatment. Unlike most examinees, Respondent obtained a good developmental history, including prenatal and birth history, school performance and social development.

c. Respondent provided a reasonable initial assessment, formulation, and differential diagnosis. He correctly identified the presenting symptoms of depression and provided the most likely diagnosis of major depression. However, in Dr. Rao's opinion, Respondent had difficulty with several aspects of the differential diagnosis. As noted above, he had initially failed to ask questions regarding mania, and when allowed to revisit the area had difficulty formulating follow-up questions. He required prompting to arrive at the conclusion that the patient's depression had psychotic features. While the case involved a clear history of PTSD and should have led to a diagnosis of PTSD, Respondent listed it only as a "rule-out" diagnosis. Respondent also proposed to rule-out a diagnosis of borderline personality disorder, but knew very few of the symptoms of the disorder.

d. Dr. Rao concluded that Respondent was able to propose part of a reasonable initial treatment plan, but the plan was not optimal in certain respects. Respondent struggled with the initial risk assessment and had to ask for more history, but ultimately came to the right conclusion that the patient did not require hospitalization. With mild prompting, Respondent correctly proposed a medical workup for potential causes of depression and recommended an appropriate panel of laboratory tests and imaging. He recommended appropriate psychosocial interventions. He proposed an appropriate initial pharmacologic treatment plan. However, when asked what he would do if the patient did not fully respond to the medication plan, Respondent did not opt for the more conservative approach most clinicians

would choose and lacked knowledge regarding these more common alternatives. Respondent's knowledge of the side effects of the two medications he suggested as alternatives if the patient did not respond, ariprazole and quetiapine, was limited.

e. Dr. Rao concluded that Respondent needs additional supervision and training before he can return to the practice of medicine. Specifically, Dr. Rao recommended clinical supervision based on thoroughness of history taking, diagnostic criteria of common psychiatric illnesses, and differential diagnosis. Dr. Rao also recommended further reading or coursework in psychopharmacology, preferably with some sort of assessment mechanism that would allow him to demonstrate proficiency.

28. Dr. Rao received seven randomly-selected patient charts provided by Respondent, but was unable to thoroughly evaluate the charts because they were largely illegible.

29. Respondent completed the psych/neuro-related version of the PRIMUM computerized test. Respondent was asked to assess and manage eight cases presenting a mix of urgent and non-urgent cases. Certain actions taken by the physician were characterized as "unfavorable," or actions that were inappropriate, risky or harmful based on the level of potential intrusiveness and potential harm to the patient. Respondent scored in the fourth quintile in one case and in the first quintile on seven cases. He took an unfavorable action in one of the cases.

30. Martin Schulman, M.D. (Shulman), Associate Professor of Family and Preventive Medicine, conducted the TSR interview. According to Dr. Schulman, Respondent got five of the eight diagnoses correct. His overall scores were in the unsatisfactory range on five cases, and in the superior range in one case. He was stronger on straightforward psychiatric cases, but did not perform as well on more complex cases that included a medical component. In Dr. Schulman's opinion, Respondent's overall medical knowledge and clinical judgment were lacking during his interview, but some of the cases were outside Respondent's specialty.

31. Respondent completed two multiple choice examinations designed by the NBME, the Pharmacotherapeutics with Behavioral Core Focus Modular Examination and the Psychiatry Clinical Science Subject Exam. In the former, Respondent scored 73 percent, which placed him in the 15th percentile when compared to the 2,000 physicians in the control group who were taking the USMLE Step 3 Exam for the first time and who had completed one to three years of residency training at the time of testing. In the latter, Respondent scored in 1st percentile when compared with a reference group of more than 6,000 first-time test takers from over 55 schools who took the test as their final clerkship examination.

32. a. Phase II took place on April 15 through 19, 2013, and Respondent again spent time at the UCSD Department of Psychiatry and the clinics it oversees under the overall supervision of Dr. Soliman. Respondent spent time with four faculty members on adult outpatient treatment rounds. He was able to ask questions of the physicians and was asked questions by them about how he would diagnose and treat the patients. Respondent completed

selected readings on psychopharmacology and psychopathology, case studies/clinical trials, professional liability, professional ethics, and patient treatments. Respondent arrived promptly for each session, remained for the duration of the clinical experience, and participated in all sessions, asking questions of the faculty he met. Respondent behaved in a professional manner. Dr. Soliman prepared a report for the PACE Program summarizing Respondent's experience and the comments and concerns of faculty members. Respondent obtained a passing score in the final written psychopharmacology exam.

b. Based on a review of the materials submitted by the other faculty members, Dr. Soliman concluded that there were areas of concern, particularly involving Respondent's fund of knowledge and his ability to interact with patients and other physicians.

33. a. One of the physicians with whom Respondent interacted was Ashraf Elmashat, M.D. (Elmashat), Associate Clinical Professor at the UCSD Department of Psychiatry, and Associate Medical Director of Community Mental Health and Medical Director of Outreach Specialty Programs, programs run by the school.

b. Dr. Elmashat met with Respondent for about one hour. He presented Respondent with the hypothetical case of a 35-year-old female suffering from bipolar disorder, and asked him to discuss the case. Initially, Dr. Elmashat asked Respondent to state the questions he would ask to obtain pertinent history from the patient. Respondent focused on the presenting complaint, but failed to obtain an adequate history, as details were missing regarding prior sexual history, prior psychiatric treatment, prior drug use, past psychiatric history, past medications, history of allergies, and family psychiatric history.

c. Dr. Elmashat asked Respondent how he would treat the patient. Respondent wanted to prescribe Depakote, an anti-seizure medication used to treat bipolar disorder, but had not inquired about the patient's other medications or if she was pregnant. In Dr. Elmashat's opinion, given the medication Respondent planned to prescribe, he should have ordered laboratory tests to rule out pregnancy. Depakote has serious side effects, including the potential for causing spinal bifida and mental retardation in fetuses. Respondent did not explain these side effects to obtain the patient's informed consent to prescribe the medication.

d. In response to a question regarding Respondent's course of action during a hypothetical follow-up visit in which the patient disclosed she was pregnant, Respondent realized he had failed to mention the laboratory tests before and stated that he should have ordered a pregnancy test.

e. Dr. Elmashat reviewed the results of his evaluation with Respondent and informed Dr. Soliman about his conclusions. Respondent agreed with Dr. Elmashat about the missing history and told the physician during this review portion of their meeting that he typically covered those matters with his patients. Dr. Elmashat agreed that a physician can improve in taking a comprehensive history by reading and practicing, especially if supervised.

34. a. Respondent was also evaluated, by Dr. McCahill, on his interactions with three standardized patients. At the start of each patient visit, Respondent was given written and verbal instructions about the presenting complaint(s) and about his tasks. With respect to his task, Respondent was directed to conduct an initial diagnostic evaluation, in which he was to assess psychiatric history and current symptoms, to gather all of the information expected to be obtained in a typical initial visit, and to make a preliminary diagnosis and treatment plan. Respondent was given 50 minutes to complete the foregoing tasks and 15 to 20 minutes to write a medical record. The notes were difficult for Dr. McCahill to read.

b. Respondent's attitude toward the standardized patients was professional, although Dr. McCahill concluded that it was a challenge to understand Respondent at times. All of the visits were brief, at 26, 24 and 25 minutes for case numbers 1, 2, and 3, respectively.

c. Dr. McCahill expressed concerns about Respondent's ability to obtain and document the patients' histories. Respondent asked all three patients about suicidal ideation, but not about homicidal ideation or about past history or current risk of self-injury. Despite not inquiring, Respondent wrote in all three progress notes that the patient "denies suicidal ideation and denies homicidal ideation." He often used a questioning style that suggested a negative answer, such as "you never had paranoia?" During the first patient visit, there were several times that Respondent asked the patient to repeat herself, such as asking three separate times during the first five minutes how long she had had the symptoms and asking about one minute apart about her father's occupation.

d. With respect to mental status examinations, Respondent did not properly perform the "serial 7s" examination, where patients are asked to count backwards seven numbers at a time, in that Respondent prompted or assisted the patients in the counting. When one of the patients answered incorrectly, Respondent did not address it. In conducting the mental status examination of a 72-year-old patient, Respondent asked how her memory was and, when she said "I don't know," he replied "It's okay," and gave her three items to recall later in the visit, but did not ask later about the items.

e. Dr. McCahill also expressed concerns about Respondent's clinical judgment and diagnoses. With respect to patient number 1, despite multiple examples of agoraphobia, Respondent diagnosed panic disorder without reference to the agoraphobia. He told patient number 1 that she might have to see a doctor about taking Zoloft or Paxil, but provided no information about how to take these drugs or about their side effects. Respondent gave patient number 2 incorrect information regarding the effect of her current medication and about the side effects of a proposed medication, Abilify. With respect to patient number 3, Respondent recommended a new medication, Zoloft, without knowing which medications the patient was taking and did not adequately provide information about potential side effects of the medication.

f. Dr. McCahill concluded that Respondent's performance fell below that expected of a psychiatrist in practice. His deficiencies extended to his knowledge base as well as his ability to obtain information and make decisions. She was also concerned about cognitive

processing issues raised by his asking repeated questions about the subjects already covered and by his failure to properly perform the three-object memory test.

35. PACE concluded that Respondent's overall performance was marked by broad spectrum deficiencies in many of the core competencies and that his current performance demonstrated a potential threat to patient safety. It issued a "Fail" grade, which PACE defines as "[S]ignif[ying] a poor performance that is not compatible with overall physician competency and safe practice. Physicians in this category performed poorly on all (or nearly all) aspects of the assessment. Alternatively, the physician could have a physical or mental health problem that prevents him/her from practicing safely. These physicians are unsafe and, based on the observed performance in the PACE assessment, represent a potential danger to their patients. Some physicians in this category may be capable of remediating their clinical competency to a safe level and some may not. We will provide our recommendations regarding remedial educational activities. The faculty and staff at the UCSD PACE Program do not give an outcome of "Fail" lightly or casually. This assignation reflects major, significant deficiencies in clinical competence, and physicians who receive this outcome, if they are deemed to be candidates for remedial education, should think in terms of engaging in a minimum of one full year of dedicated study and other learning activities requiring on average 30 to 40 hours per week. Under no circumstances will the UCDS PACE Program allow a physician assistant [*sic*] to participate in a re-assessment less than six months from the time of the completion of the initial assessment." (Exh. 6, at pp. 19-20.)

36. At the hearing, Dr. Norcross opined that, given that Respondent failed PACE twice, he should undergo extensive, residency-like training for about one year to prepare for re-testing.

37. Respondent tried to prepare for PACE, but it was difficult with his full-time practice and family obligations. By way of explanation of his performance, Respondent testified that computer components, such as the Microcog and the PRIMUM, required rapid completion and were confusing. He also learned from his performance, and the details are discussed below.

Respondent's Remediation Efforts After Failing PACE in 2013

38. After reviewing the PACE report, which he obtained during discovery in the instant case, and listening to the hearing testimony from PACE witnesses, Respondent testified that he realizes what his mistakes were and knows the areas in which he needs to improve. Many of his mistakes were in taking history, which he partly attributes to examination stress and to his rushing through the exercises. He was trained to move fast and his busy practice has reinforced the need for speed. In his private practice, he has checklists to assist him. If allowed to return to practice, Respondent plans to reduce the number of patients and to take more time with each patient. He also plans to prepare all his notes in electronic form, a process he had begun before his license was suspended.

39. After the suspension of his license, Respondent started reading medical literature every day to increase his knowledge. He regularly reviews the "Beat the Boards" course

materials prepared by the American Physician for Advanced Professional Studies, the Desk Reference to the Diagnostic Criteria from the Diagnostic and Statistical Manual Five, the Pocket Handbook of Clinical Psychiatry, the Boarding Time Book, the Psychotropic Prescribing Guide, and the diagnostic algorithms prepared by the American Psychiatric Association and others. He has also reviewed multiple audiotapes and videotapes on various psychiatric disorders.

40. Respondent has completed the following continuing medical education online programs: Focus on Prodrome, First-episode, and Early-phase Schizophrenia (December 10, 2013; .75 Category 1 credits); Focus on Treatment-Resistant and Refractory Schizophrenia (December 7, 2013; .75 Category 1 credits); Online Journal Article – A practical approach to prescribing antidepressants (December 19, 2013; 1.0 Category 1 credits); Assessing the Impact of Binge Eating Disorder: Focus on Your Practice (December 26, 2013; .5 Category 1 credits); Emerging Clinical Date on Treatment Options or Managing Depression in Bipolar Disorder (December 26, 2013; .5 Category 1 credits); Purdue College of Pharmacy internet-based activity (December 27, 2013; .5 Category 1 credits); The Case: 44-year-old Man With Depression and Fatigue (December 28, 2013; .5 Category 1 credits); Improving the Recognition and Treatment of Bipolar Depression (December 28, 2013; 1 Category 1 credits); Improving Outcomes in Schizophrenia: Long-acting Depots and Long-term Treatment (December 28, 2013; 1.25 Category 1 credits); Major Depressive Disorder and Treating to Remission (January 10, 2014; .50 Category 1 credits); Diagnosing Psychiatric Disorders – The Synchronization of DSM-5 and ICD-10-CM (January 11, 2014; 1.5 Category 1 credits); University of Florida College of Medicine internet-based activity (January 15, 2014; .50 Category 1 credits). He also attended the September 30 to October 3, 2013, U.S. Psychiatric and Mental Health Congress continuing education program in Las Vegas, Nevada, where he received 27 Category 1 credits in 18 different subjects pertaining to psychiatry.

Additional Experts Who Have Evaluated Respondent's Competence

41. a. Respondent called three expert witnesses, all of whom have experience evaluating physician competency. They are familiar with PACE, and reviewed the final 2009 and 2013 PACE reports before their meetings with Respondent. Each of these individuals independently evaluated Respondent's competence and testified about his evaluation.

b. Samuel I. Miles, M.D., Ph.D. (Miles) received his medical degree from New York Medical College, New York, New York, in 1974, completed a three-year psychiatry residency at Cedars-Sinai Medical Center in Los Angeles, California, in 1978, and obtained his doctorate from the University of Southern California Psychoanalytic Institute in 1986. He is board certified by the American Board of Psychiatry and Neurology in psychiatry with added qualifications in forensic psychiatry. He is engaged in the private practice of psychiatry and spends part of his time in forensic psychiatry matters, including opining about physician competence and practice in accordance with the standard of practice. He has worked as an assistant clinical professor of psychiatry at the University of California, Los Angeles (UCLA), School of Medicine.

c. Brian Jacks, M.D. (Jacks) received his medical degree in 1967 from the University of Toronto, Ontario, Canada. After a one-year internship at the Vancouver General Hospital, Vancouver, British Columbia, Canada, Dr. Jacks completed a three-year psychiatry residency at the Los Angeles County/University of Southern California (USC) Medical Center. He holds certificates from the American Board of Psychiatry and Neurology in adult psychiatry and in child and adolescent psychiatry. He has been engaged in the practice of general psychiatry in Beverly Hills, California, since 1976. Dr. Jacks has been part of the clinical faculty at the USC School of Medicine since 1979. Dr. Jacks teaches a course to help physicians pass specialty board exams, which includes lectures and assessment of the participants' diagnostic interview techniques. Dr. Jacks does forensic consulting regarding physician competence and adherence to the standard of care, and has in the past his provided his services to the Board.

d. Alan L. Schneider, M.D. (Schneider) graduated from the USC School of Medicine in 1983. After one year in an internal medicine residency, Dr. Schneider switched to a psychiatry residency, which he completed in 1987 at UCLA/Cedars Sinai Medical Center. He was a fifth-year resident at the UCLA/Sepulveda VA Medical Center, where he was the chief resident in the psychiatry training program and where he performed research. Dr. Schneider holds certifications from several boards, including the American Board of Psychiatry and Neurology and the American Board of Addiction Medicine. He is actively engaged in the practice of psychiatry, despite spending approximately 40 percent of his time in teaching and administrative duties. Dr. Schneider holds academic appointments at the UCLA School of Medicine (associate clinical professor of psychiatry), at the USC School of Medicine (clinical assistant professor of psychiatry and behavioral sciences), and at the University of California, Irvine, School of Medicine (associate clinical professor). Since 2011, he has been the Director, Chemical Dependency and Opiate Treatment Centers of the Greater Los Angeles VA System. Dr. Schneider evaluates cases for the Board. In his teaching and Board-evaluator capacities, Dr. Schneider has evaluated the competency of physicians on multiple occasions.

42. a. Dr. Jacks met with Respondent on two occasions. The first meeting occurred on September 23, 2013, and lasted about 1.5 hours. Dr. Jacks conducted a psychological evaluation of Respondent, which included a mini mental health evaluation and administration of the Minnesota Multiphasic Personality Inventory-2. All testing was within normal limits. Dr. Jacks did not detect any cognitive problems and did not deem further neurologic testing necessary.

b. Dr. Jacks discussed the findings of the PACE Program with Respondent and probed into some of the cases presented to Respondent to gain better understanding about his performance.

c. Dr. Jacks made several recommendations for Respondent to improve. He recommended that Respondent speak slower and that he take more time with his patients. He suggested that Respondent review and use treatment algorithms. He recommended that Respondent brush up on pharmacology. Additional study would broaden his medical

knowledge and help get rid of "bad habits." Dr. Jacks agreed that Respondent's current course of study, set forth in factual finding number 39 is appropriate.

d. Dr. Jacks had requested Respondent to bring two "typical" patient files, and found them in compliance with the standard of care. On cross-examination, he conceded that the charts were "a little difficult" to read.

e. During the second visit, for about one hour on February 1, 2014, Dr. Jacks asked general questions and presented hypothetical cases to test Respondent's knowledge and clinical skills. Dr. Jacks noticed improvement from the first meeting. It seemed Respondent had taken his recommendations to heart and started working on improving his performance.

43. In Dr. Jack's opinion, Respondent's problems at PACE were rooted in language and communication difficulties, poor computer skills, and the speed with which Respondent completed his assignments in the PACE Program. Respondent is very difficult to understand if he speaks too fast, as he tended to do in interactions with Dr. Jacks. His patient visits with mock patients at PACE were very brief, either due to a misunderstanding of the assignment or to poor time management. Respondent was "rusty" on his knowledge about some medications.

44. In Dr. Jacks's opinion, Respondent can safely practice psychiatry. Respondent does not need to repeat the PACE Program, but would nevertheless benefit from completing a pharmacology course and from other continuing education. Practice monitoring would also be helpful.

45. a. Dr. Miles met with Respondent on two occasions, February 7 and March 10, 2014. Dr. Miles had read the final report prepared by PACE before the first meeting with Respondent. The first meeting lasted approximately 2.5 hours and started with Dr. Miles obtaining information about Respondent and his situation, including that he had failed the PACE Program on two occasions. Dr. Miles conducted an oral competency examination of Respondent, in which Respondent presented a case and Dr. Miles asked questions about the hypothetical case. Dr. Miles also presented several case vignettes and asked Respondent about how he would handle them.

b. At the conclusion of the first meeting, Dr. Miles was concerned with Respondent's presentation, which he deemed to lack in organization. For instance, Respondent at times discussed the presentation of the patient concurrent with his findings; Respondent was able to obtain an appropriate history, but did not separate it from his analysis. Dr. Miles made suggestions for Respondent to better analyze and organize his presentations. While Respondent seemed to have the requisite knowledge, his presentation raised questions about his competence.

c. In the second meeting, which lasted 1.5 hours, Respondent was again asked to present a case and to discuss case vignettes. Respondent's presentations and responses were much improved, and Dr. Miles no longer had concerns regarding Respondent's organization skills. Respondent was able to present the case in a clear manner, and when Dr.

Miles altered facts and asked questions about how the new facts changed his opinion Respondent presented cogent responses. The better organization also led Respondent to quicker realization in one of the vignettes that laboratory studies were warranted before a new medication was tried. Dr. Miles was satisfied that Respondent was able to properly assess the patients and to devise treatment plans for them.

46. a. Given Respondent's improved performance in the second meeting, Dr. Miles concluded that Respondent's deficiencies in the first meeting were the result of bad habits and poor education and that he was capable of changing the bad habits and educating himself to practice in an acceptable manner. Given his performance, Respondent does not need to take PACE again, but would benefit from the Program's practice supervision services.

b. In Dr. Miles opinion, Respondent's medical knowledge met the standards of competence. Respondent informed Dr. Miles about the steps he is taking to improve his medical knowledge, summarized in factual finding number 39, and Dr. Miles opined that it was a useful and adequate course of study. In Dr. Miles's opinion, Respondent can safely practice medicine.

47. Dr. Miles discounted the value of the Microcog in assessing foreign-born individuals for whom English is a second language, as such individuals are not included in the normed group to which Respondent's results were compared. Those whose first language is not English may be slower in completing the timed test, which may not be a reflection of their cognitive ability. Significantly, Respondent's ability to organize his presentation for the second meeting with minimal remediation counters any claim of cognitive impairment. In Dr. Miles's opinion, therefore, there is no need for further neurological evaluation or testing.

48. a. Dr. Schneider evaluated Respondent's competency on February 19, 2014. In order to assess Respondent's knowledge and ability to correctly diagnose a presenting problem, Dr. Schneider employed the services of a seasoned mock patient, an experienced individual trained to present difficult situations in tests of residents. Respondent spent 30 to 35 minutes with the patient. At the conclusion of the encounter, Dr. Schneider asked questions about Respondent's thinking process, asked hypothetical questions regarding care of the patient if certain facts were changed, and asked other questions to test Respondent's knowledge.

b. The 55-year-old mock patient presented a particularly complicated combination of rapid cycling bipolar depression, comorbid attention deficit disorder and early childhood emotional and physical trauma. Respondent carried himself in a professional manner and attempted to put the patient at ease. His ability to establish rapport was hampered by his heavy accent, which made him difficult to understand at times. Respondent became more comfortable as the interview proceeded.

c. Dr. Schneider was satisfied that Respondent conducted a competent examination of the mock patient, and his subsequent exchange with Dr. Schneider confirmed his competence. Respondent had a base understanding of major psychiatric illnesses and their management. Respondent performed a rather complex mental status examination and

formulated a reasonable treatment plan. Respondent covered all major critical areas, such as current medications, past medications, medical history, family history, substance abuse and review of systems. He adequately explored the pertinent symptom complex of the presenting problem. Respondent adequately derived the pertinent diagnoses. Respondent was organized, and Dr. Schneider was surprised about contrary comments by PACE evaluators. Respondent explained the risks and benefits of his recommended treatment.

49. Dr. Schneider is familiar with the Microcog and deems its usefulness limited when assessing non-English speakers or those of a different culture. Respondent was oriented and did not evidence any cognitive impairment during his meeting with Dr. Schneider.

50. In Dr. Schneider's opinion, Respondent is competent to practice psychiatry and does not present a clear and present danger to patients. He recommended practice monitoring on a quarterly basis for one year, in which a monitor would pick three of four files and discuss the cases with Respondent.

51. a. Respondent also called Moiez Khankhanian, M.D. (Khankhanian), the principal physician at Sunset Psychiatric Medical Center. Respondent has worked for Dr. Khankhanian for approximately 17 to 18 years, and the two had daily contact until the suspension of Respondent's certificate. Dr. Khankhanian described Respondent as a responsible person and family man. Respondent has not acted in any manner that would cause Dr. Khankhanian to question his cognitive abilities.

b. Dr. Khankhanian has not received any complaints about the care Respondent provided any of his patients. In fact, Dr. Khankhanian has had greater contact with Respondent's patients since the suspension order issued, as he provides care to some of the patients and arranged for the care of others. He testified that the patients miss Respondent and keep asking about when Respondent is coming back.

c. Dr. Khankhanian and Respondent discussed cases occasionally and Dr. Khankhanian has no reason to doubt Respondent's competency. He has reviewed Respondent's patient charts and has found them very thorough, adequate and complete, despite the effort needed at times to read them. In following up with the care of the patients, Dr. Khankhanian noted, based on his review of the files and his contact with the patients, that Respondent made the appropriate diagnoses and provided the necessary care.

Additional Factual Findings Regarding Cognition and Competence

52. The results of the Microcog screening tests and Dr. Perry's testimony are sufficient to establish that Respondent warrants additional neurologic evaluation, referred to by Drs. Norcross and Perry as a "fitness for duty" assessment. The scores are indeed low and lower overall in 2013 than in 2009. While the test is only a screening device and does not establish that Respondent is impaired, it raises concerns in multiple areas that cannot be ignored. The Microcog results cannot be entirely disregarded due to the test's limitations in assessing foreign-born individuals for whom English is a second language because Respondent obtained

low scores in some nonverbal subtests. Dr. Jacks performed a mini mental evaluation, a less rigorous screening test, the results of which are insufficient to warrant disregarding the Microcog results. Moreover, neither Dr. Jacks nor Dr. Simon performed a broader psychological assessment that would have fully addressed the concerns raised by the Microcog tests.

53. The evidence regarding Respondent's performance at PACE is sufficient to establish that at the conclusion of the second PACE program Respondent lacked sufficient knowledge to competently discharge his duties as a physician. As Dr. Norcross correctly noted in reviewing the input from faculty members who directly worked with Respondent, the same concerns were present whether Respondent met with a mock patient, engaged in computer assessments on PRIMUM, or discussed a case with a faculty member. There were concerns about his body of knowledge, his ability to obtain an adequate history, and his ability to derive the correct diagnosis and treatment plan, all of which are basic to the practice of medicine. While some of the noted deficiencies may have been the result of Respondent's "bad habits" and failure to spend enough time with the patients or on the assignments, the fact remains that there are documented deficiencies.

54. In Dr. Norcross's opinion, at least one year should pass before any reassessment of Respondent's competency. In addition, Dr. Norcross recommended a qualitative intensification of this study, in the nature of participation in an informal residency program, a mentorship, or other educational experience in which Respondent can interact with and learn from others.[2]

55. Respondent has done much since October 2013 to overcome the deficiencies identified by PACE Program physicians. Respondent realizes that he has developed bad habits over the years and that he needs to change some of his practices and customs. He agrees that he needs to take more time with patients and to speak slower. His efforts to increase his knowledge and improve his analytical skills are indeed impressive and should continue. As established by the testimonies of Drs. Jacks, Schneider and Simon, these efforts are bearing fruit and Respondent has progressed from the time he was last at PACE. In their opinions, which were independently derived, Respondent has addressed the shortcomings that contributed to his difficulties with PACE and is presently able to safely practice medicine. These opinions have been considered in fashioning the order below. However, the results from PACE's thorough and systematic review of Respondent's competency, even if predating Respondent's remediation efforts, require further testing and verification before Respondent can resume the practice of medicine.

Other Allegations and Arguments

56. Except as set forth in this Decision, all other allegations in the accusation and all other arguments by the parties, lack merit or constitute surplusage.

---

[2] At the hearing, Dr. Norcross testified that PACE was able to arrange such an informal residency for another physician, and it is hoped that the same could be done for Respondent.

LEGAL CONCLUSIONS

1. Complainant bears the burden of proving, by clear and convincing evidence to a reasonable certainty, that cause exists to discipline Respondent's physician's and surgeon's certificate. (*Ettinger v. Board of Medical Quality Assurance* (1985) 135 Cal.App.3d 853, 856; *James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1104.) This means that the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal –so clear as to leave no substantial doubt, and sufficiently strong to command the unhesitating assent of every reasonable mind. (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478.)

2. "Incompetence generally is defined as a lack of knowledge or ability in the discharge of professional obligations." (*James v. Bd. of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109.) Cause exists to discipline Respondent's license pursuant to section 2234, subdivision (d), in that Complainant established that Respondent lacks the requisite knowledge or ability to discharge his professional obligations, by reason of factual finding numbers 10 through 20, 24 through 37, 41 through 51, and 53 through 55.

3. The purpose of licensing statutes and administrative proceedings enforcing licensing requirements is not penal but public protection (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 784-786; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476). Respondent has undergone significant remediation since October 2013, and three very qualified experts opined that he has overcome his deficiencies and is now able to return to the practice of medicine. However, given the results from PACE's thorough, systematic, and relatively recent review of Respondent's competency, further education, testing and verification are required before Respondent can resume the practice of medicine.

Dr. Norcross's opinion that at least one year should pass before any reassessment of Respondent's competency is well-taken, as is his recommendation of participation in an informal residency program, a mentorship, or other educational experience in which Respondent can interact with and learn from others. Given that Respondent has been working on his own with good results for about six months, an additional six-month period of education should be sufficient. Such additional study and education should occur before Respondent returns to practice. As set forth in factual finding number 52, a psychological evaluation is also warranted, and should be completed before Respondent returns to practice. Upon return to practice, practice monitoring, as suggested by Drs. Jacks, Miles, Rao and Schneider is also appropriate.

Accordingly, the order that follows is necessary, and sufficient, for the protection of the public.

ORDER

Physician's and Surgeon's Certificate number A 53624 issued to Dayalal D. Tank, M.D., is revoked, which revocation is stayed for five years subject to the following terms and conditions.

1. Psychiatric Evaluation. Within 30 calendar days of the effective date of this Decision, Respondent shall undergo and complete a psychiatric evaluation (and psychological and/or neurological testing, if deemed necessary) by a Board-appointed board certified psychiatrist, who shall consider any information provided by the Board or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the Board or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing. Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Board or its designee.

Respondent shall not engage in the practice of medicine until notified by the Board or its designee that Respondent is mentally fit to practice medicine safely. The period of time that Respondent is not practicing medicine shall not be counted toward completion of the term of probation.

2. Program of Study. Respondent shall continue to study for at least six months in an informal residency program, a mentorship, or another educational experience in which Respondent can interact with and learn from others. Respondent shall seek PACE's cooperation and assistance in the design and implementation of such program. If PACE is unable to find a program, Respondent may seek the assistance of Drs. Jacks, Miles, or Schneider in obtaining the educational experience. Any program of study is subject to approval by the Board or its designee.

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

3. Oral Examination. Within 60 calendar days of completion of the program set forth in Condition number 2, and after having satisfied condition number 1, Respondent shall take and pass an oral examination, administered by the Board or its designee. The examination shall address the areas of deficiency identified by PACE. The examination shall be conducted in accordance with section 2293, subdivisions (a) and (b). If Respondent fails the first examination, Respondent shall be allowed to take and pass a second examination. Failure to pass the required oral examination within 180 calendar days after satisfaction of probation condition numbers 1 and 2 is a violation of probation. Respondent shall pay the costs of all examinations.

Respondent shall not practice medicine until he has passed the required examination and has been so notified by the Board or its designee in writing. This prohibition shall not bar Respondent from practicing in a clinical training program or program of study approved by the Board or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

4. Practice monitoring. Within 30 calendar days of having been cleared to return to the practice of medicine, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. Unless approved by the Board, a monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

Within 60 calendar days of his return to the practice of medicine, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of his return to practice, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit quarterly written reports to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior

approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by PACE, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

5. Education Course. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, 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 per year, for each year of probation. 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. At least 10 hours annually of this coursework must be in psychopharmacology.

6. Notification. Within seven days of returning to the practice of medicine, Respondent shall provide a true copy of the Decision in this matter to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. Supervision of Physician Assistants. During probation, Respondent is prohibited from supervising physician assistants.

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

9. Quarterly Declarations. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance

with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. General Probation Requirements. Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

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

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

After his return to the practice of medicine, Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days. In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. Interview with the Board or its Designee. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

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

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

Respondent's period of non-practice while on probation shall not exceed two years.

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

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

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

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

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

16. Probation Monitoring Costs. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATED: 6/11/14

SAMUEL D. REYES
Administrative Law Judge
Office of Administrative Hearings