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

In the Matter of the Accusation Against: **Fayez Romman, M.D.** PO Box 581231 Elk Grove, CA 95758-0021 Physician's and Surgeon's Certificate No. A 79983, Respondent.	Case No. 800-2017-039103 **ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 26, 2002, the Medical Board issued Physician's and Surgeon's Certificate Number A 79983 to Fayez Romman, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2022, unless renewed.

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JURISDICTION

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

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

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
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> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
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> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
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> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
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> ...

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

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7. Section 2256 of the Code states: Any intentional violation of Sections 5326.2 to 5326.8, inclusive, of the Welfare and Institutions Code, relating to the rights of involuntarily confined inpatients, constitutes unprofessional conduct.

8. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provisions of services to their patients constitutes unprofessional conduct.

FACTUAL ALLEGATIONS

9. Respondent is a psychiatrist who at all times relevant to the charges brought herein worked at Sierra Vista Hospital in California.

Patient A

10. On or about May 11, 2017, Patient A[1], a minor, was taken to the emergency room and placed in custody pursuant to California Welfare and Institutions Code section 5150[2], after making statements of self-harm.

11. On or about May 12, 2017, Patient A was admitted into Sierra Vista Hospital. The admitting physician evaluated the patient on this day. A separate physician provided care from around May 13, 2017 through May 14, 2017, during which he placed a hold on Patient A pursuant to California Welfare and Institutions Code section 5250[3]. This physician placed this

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[1] To protect the privacy of the patients involved, the patient names have not been included in this pleading. Respondent is aware of the identity of the patients referred to herein.

[2] California Welfare and Institutions Code section 5150 provides that when a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services.

[3] California Welfare and Institutions Code section 5250 states: "If a person is detained for 72 hours under the provisions of Article 1 (commencing with Section 5150), or under court order for evaluation pursuant to Article 2 (commencing with Section 5200) or Article 3 (commencing with Section 5225) and has received an evaluation, he or she may be certified for not more than 14 days of intensive treatment related to the mental health disorder or impairment by chronic alcoholism, under the [conditions listed in subsections (a) through (d)]."

hold on the patient due to continued suicidal ideation. The admitting physician saw Patient A once more around May 15, 2017, before taking a planned absence from work. Respondent assumed care of Patient A from around May 16, 2017, through Patient A's discharge on May 22, 2017.

12. On or about May 14, 2017, Patient A's father requested Patient A be discharged from the hospital. However, around May 17, 2017, the father agreed to voluntarily keep Patient A in the hospital. Later on that day, Patient A's father changed his mind and requested Patient A be discharged. Because Respondent did not believe Patient A was ready for discharge, Respondent placed Patient A on a second hold pursuant to Welfare and Institutions Code section 5150.

13. On or about May 18, 2017, a Certification Review Hearing was held in Sacramento County to determine whether Patient A should remain in the hospital based upon concerns she was a continued danger to herself. The hearing officer considered the evidence and determined there was probable cause to believe that Patient A did in fact pose a danger to herself. Thus, based on this ruling, the hospital had the authority pursuant to California Welfare and Institutions Code section 5250, to continue to treat Patient A for an additional 14 days from when the hold was placed on May 17, 2017.

14. Patient A's medical chart reflects entries from the professionals who treated her, including the admitting physician, covering physician, Respondent, nurses, case managers and social workers. Patient A's medical chart indicates she was diagnosed with Major Depressive Disorder, recurrent. Patient A disclosed to two of the case managers that she lived with her father and his new wife. Patient A expressed grief over her separation from her biological mother, who lived in Nevada. Though this information was readily known, the medical chart does not reflect the biological mother was contacted to provide consent for treatment. The medical chart does not have a copy of a divorce decree nor custody agreement indicating Patient A's father had full custody. Thus, the presumption in the absence of that documentation is that there is split legal custody. In order to engage in treatment, both parents were required to consent.

15. While hospitalized from about May 12, 2017, through May 22, 2017, Patient A went through several legal proceedings pursuant to California Welfare and Institutions Code section

5150 and 5250. The "Physician's Order Sheet" and "legal holds section" within the medical chart should at all times contain the status of these legal proceedings to ensure protection of Patient A's civil rights. Yet, the documentation in these sections is inconsistent and at times, does not accurately describe whether the patient was in the hospital on voluntary or involuntary status.

Patient B

16. On or about June 27, 2019, Patient B, was admitted to the emergency room and subsequently placed in custody pursuant to California Welfare and Institutions Code section 5150, after a determination of being gravely disabled.

17. On or about July 1, 2019, Patient B was transferred to Sierra Vista Hospital to obtain treatment for her underlying medical as well as psychiatric conditions. Upon admission, Patient B presented with disorganized, tangential ideas. Patient B was difficult to diagnose due to her inability to respond to questions based on her manic state.

18. Prior to entering Sierra Vista, Patient B had a history of abnormal liver enzymes, abnormal renal panel, and hypertension. Upon admission to Sierra Vista, Patient B's blood pressure was 199/85 with a pulse of 98. Patient B was placed on an alcohol detoxification protocol and was transferred to the emergency room overnight for stabilization. While in the hospital, Patient B had an extensive medical workup. Patient B had ongoing blood pressure elevation over the first three weeks of her stay as well as dehydration and headaches. On or about July 10, 2019, Patient B again had to be transferred to the emergency department. Despite these symptoms, Respondent did not diagnose Patient B with alcohol withdrawal nor did he document it in Patient B's discharge paperwork.

19. On or about July 2, 2019, a hold was placed on Patient B pursuant to California Welfare and Institutions Code section 5250 because the patient was disorganized, gravely disabled, and unable to care for herself.

20. During the course of Patient B's hospital stay, she was diagnosed with Schizoaffective Disorder, bipolar type, cannabis abuse, hypertension and abnormal liver enzymes. Respondent attempted to treat Patient B with antipsychotic medications. However, Patient B was noncompliant with her medications and often refused them. Patient B refused medications on or

about July 5, 2019, July 9, 2019, July 10, 2019, July 11, 2019, July 13, 2019, July 14, 2019, July 16, 2019, July 17, 2019, July 19, 2019, July 20, 2019, July 22, 2019, and July 23, 2019.

21. On or about July 5, 2019, a Certification Review Hearing was held in San Joaquin County to determine whether Patient B should remain in the hospital based upon concerns she was gravely disabled. The hearing officer considered the evidence and determined there was probable cause to believe that Patient B was in fact gravely disabled. Thus, based on this ruling, the hospital had the authority pursuant to California Welfare and Institutions Code section 5250, to continue to treat Patient B for an additional 14 days from date of the initial hold on July 2, 2019.

22. On or about July 10, 2019, Respondent filed a declaration with the Sacramento County Court to explain that Patient B lacked the capacity to consent to the medications prescribed to her. Based on those declarations, Respondent requested the court allow him to treat Patient B with specific medications against her will including the following[4]: Seroquel, Haldol, Risperidone, Thorazine, Geodon and Lithium[5]. A Sacramento County Superior Court Judge approved this request on July 11, 2019 (Riese Hearing). There is no documentation from Respondent in the "Physician's Orders" on or after July 11, 2019, to explain that Patient B could be treated involuntarily.

23. On or about July 15, 2019, pursuant to California Welfare and Institutions Code section 5270.15[6], another hold was placed on Patient B because the patient continued to exhibit symptoms demonstrating grave disability.

24. On or about July 17, 2019, a Certification Review Hearing was held in Sacramento County to determine whether Patient B should remain hospitalized for an additional 30 days based upon concerns she was gravely disabled. The hearing officer considered the evidence and determined there was probable cause to believe that Patient B was gravely disabled. Thus, based

[4] A class of psychotropic medications used to treat symptoms of schizophrenia and bipolar disorder.

[5] Lithium is a mood stabilizer.

[6] California Welfare and Institutions Code section states that upon the completion of a 14-day period of intensive treatment pursuant to Section 5250 , the person may be certified for an additional period of not more than 30 days of intensive treatment under both of the [conditions listed in subsections (1) and (2)].

on this ruling, the hospital had the authority pursuant to California Welfare and Institutions Code section 5270, to continue to treat Patient B for an additional 30 days from July 15, 2019. Respondent did not document the "Physician's Orders" to reflect Patient B's legal status. In fact, there were no "Physician's Orders" at all from about July 12, 2019 through July 16, 2019.

25. On or about July 19, 2019, Respondent filed an additional declaration with the Sacramento County Court to explain that Patient B continued to lack the capacity to consent to the medications prescribed to her. Respondent again requested the court allow him to treat Patient B with the medications against her will. A Sacramento County Superior Court Judge approved this request on about July 23, 2019 (Riese Hearing).

26. Although there were two Riese hearings for Patient B, there is no documentation in the "Physician's Orders" to note the court's ruling from July 11, 2019. Namely, the "Physician's Orders" do not document that Patient B could be medicated with specific medications against her will.

27. On or about August 5, 2019, Patient B was discharged Against Medical Advice (AMA), with a diagnosis of Schizoaffective Disorder, bipolar type and cannabis abuse. Though there is mention of medical issues consisting of hypertension, anemia, abnormal liver enzymes and abnormal renal panel, there is no mention that Patient B suffered from symptoms consistent with alcohol withdrawal.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

28. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), and section 2256, of the Code in that he was grossly negligent in his care and treatment of Patients A and B. The circumstances set forth in Paragraphs 9 through 27, above, are incorporated here by reference as if fully set forth herein.

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

(a) Failing to consistently and accurately document within the "Physician's Orders" and "legal holds section" in Patient A's medical chart whether Patient A was in the hospital

voluntarily or involuntarily pursuant to California Welfare and Institutions Code section 5150 and 5250;

(b) Failing to identify and document the person(s) able to provide consent for treatment for Patient A, a minor.

30. Respondent was grossly negligent in his care and treatment of Patient B for his acts and omissions, including but not limited to, the following:

(a) Failing to consistently and accurately document within the "Physician's Orders" in Patient B's medical chart whether Patient B was in the hospital voluntarily or involuntarily pursuant to California Welfare and Institutions Code section 5270;

(b) Failing to document Patient B's medical chart to reflect the Sacramento Superior Court Orders from July 11, 2019, granting the hospital consent to administer specific medications to Patient B on an involuntary basis;

(c) Failure to diagnose alcohol withdrawal;

(d) Failure to document Patient B's emergency room visits due to alcohol withdrawal.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

31. Respondent is subject to disciplinary action under sections 2234, subdivision (c), of the Code in that he was repeatedly negligent in his care and treatment of Patient's A and B. The circumstances set forth in Paragraphs 9 through 30, above, are incorporated here by reference as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

32. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records in his care and treatment of Patients A and B. The circumstances set forth in Paragraphs 9 through 30, above, are incorporated here by reference as if fully set forth herein.

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FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

33. Respondent is subject to disciplinary action under sections 2234 and 2256 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrated an unfitness to practice medicine. The circumstances set forth in Paragraphs 9 through 30, above, are incorporated here by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 79983, issued to Fayez Romman, M.D.;

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

3. Ordering Fayez Romman, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: NOV 09 2020

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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