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

In the Matter of the Accusation Against: **Donald Myron Hilty, M.D.** **4250 Auburn Blvd.** **Sacramento, CA 95841-4100** **Physician's and Surgeon's Certificate No. G 75437,** Respondent.	Case No. 800-2021-084404 **ACCUSATION**

PARTIES

1. Reji Varghese (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 October 27, 1992, the Medical Board issued Physician's and Surgeon's Certificate Number G 75437 to Donald Myron Hilty, 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 October 31, 2026, 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 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.
>
> (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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> (d) Incompetence.
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> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
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> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board no later than 30 calendar days after being notified by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.
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> (h) Any action of the licensee, or another person acting on behalf of the licensee, intended to cause their patient or their patient's authorized representative to rescind consent to release the patient's medical records to the board or the Department of Consumer Affairs, Health Quality Investigation Unit.
>
> (i) Dissuading, intimidating, or tampering with a patient, witness, or any person in an attempt to prevent them from reporting or testifying about a licensee.

COST RECOVERY

5. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

6. Respondent is a psychiatrist, Board-certified by the American Board of Psychiatry and Neurology. He is employed as the Chief Medical Officer of Heritage Oaks Hospital (an acute care psychiatric hospital) in Sacramento, California.

7. Patient 1 was a 90-year-old woman in March of 2021.[1] Respondent is married to Patient 1's granddaughter. During the spring of 2021, as Patient 1's health was failing, several of Patient 1's sons and daughters were engaged in a dispute over the disposition of Patient 1's assets upon her death. Patient 1's older son sought to maintain the status quo for her estate plan, while Patient 1's younger son and a group of sisters sought to alter the estate plan to disinherit the older brother in favor of the younger son. Respondent's mother-in-law (Patient 1's daughter), belonged to the group of family members seeking to alter the estate plan to disinherit the older son in favor of the younger son.

8. In approximately late March of 2021, Patient 1 began exhibiting neurological symptoms including weakness, difficulty ambulating and presenting with a left-sided face droop.

9. On or about March 28, 2021, Respondent was present at Patient 1's home along with several of her family members. Respondent observed that Patient 1 appeared visibly ill. He approached her and inquired about her health. During his interview with Board investigators, Respondent stated that he was unaware of the family dispute surrounding Patient 1's estate when he approached her on March 28, 2021, to provide medical care. Respondent maintained to Board

[1] The patient will be referred to as Patient 1 in order to protect her privacy.

investigators that his sole purpose in meeting with Patient 1 on or about March 28, 2021, was to assist her with her medical condition and refer her to further treatment if needed.

10. Respondent stated that he performed a Mini Mental State Exam, (MMSE), on Patient 1 at her home on March 28, 2021. Although Respondent did not maintain contemporaneous medical records of his visit with Patient 1, he stated that he documented his medical treatment of her after the fact from memory and from notes he wrote. He stated that he obtained a medical history from Patient 1 herself, as well as information about her past medical history obtained from her family members and notes that they maintained about her medical history. The medical records Respondent produced to the Board contain a progress note of his treatment of Patient 1 on March 28, 2021. In the progress note, Respondent documented that Patient 1 had intact orientation, memory, and attention.[2] Respondent told Board investigators that due to the facial droop, and one-sided lack of strength and coordination, he believed Patient 1 may have suffered a recent stroke. However, he did not believe she was experiencing a medical emergency on March 28, 2021, and instead recommended that her family contact her primary care provider for follow-up and possibly physical therapy or occupational therapy.

11. The following day, on or about March 29, 2021, Patient 1's family took her to the Emergency Room. Patient 1 was found to have two tumors in the frontal lobe of her brain. The tumors were suspected to be glioblastomas, a very serious form of brain cancer. Patient 1 was also diagnosed with hyponatremia related to the brain tumors.

12. Patient 1 elected not to undergo chemotherapy or further treatments for the brain tumors. On or about April 1, 2021, she was discharged home where she received hospice care for the next several weeks until her death on June 5, 2021.

[2] The medical records Respondent produced to the Board for Patient 1 do not contain an MMSE form dated March 28, 2021, but do contain one for April 4, 2021. The documents from the civil lawsuit about Patient 1's estate in Sacramento Superior Court contain an MMSE form completed by Respondent of Patient 1 for March 28, 2021. Respondent gave conflicting statements to the Superior Court and Board Investigators whether he completed an MMSE on March 28, 2021, or April 4, 2021, and whether either of these evaluations were partial or complete. There are numerous additional conflicts between his statements and the records produced to the Board and the records produced in the Superior Court as described infra.

13. On or about April 4, 2021, Respondent documented a second medical encounter with Patient 1, at her home. For this medical encounter, Respondent documented that he completed an MMSE on Patient 1 and that she obtained a final score of 29/29. The records Respondent produced contain an MMSE form, for April 4, 2021, but apart from the form showing the score, there are no details about how she performed on the exam. Again, in the progress notes for April 4, 2021, Respondent documented that Patient 1 had intact concentration, memory, and orientation. At the April 4, 2021 medical encounter, Respondent was aware of, and documented, that Patient 1 had been hospitalized on March 29, 2021, and diagnosed with neoplasm.

14. On or about April 9, 2021, a speech therapist with Sutter Health visited Patient 1 at her home and conducted an assessment of her mental state. The speech therapist performed an MMSE on or about April 9, 2021 and noted that Patient 1 scored 12/30 on the MMSE. The speech therapist detailed some of the errors Patient 1 showed, which were consistent with reports from other medical providers and demonstrated cognitive impairment due to the brain tumors. For example, Patient 1 drew a clock face that was distorted and continued the numbers of the clock up to 16 instead of stopping at 12. Patient 1 was unable to identify certain shapes and could recall only one of five words.

15. In early April, after Patient 1 was discharged home from the hospital, Patient 1's younger son contacted attorney G.F. seeking to alter his mother's estate plan to transfer her home—the only valuable asset of the estate—to himself. This would require Patient 1 to sign documents amending the family trust and transferring the property. Attorney G.F. spoke with Patient 1 about this and was dissatisfied with the clarity of her responses. He refused to participate in the alteration of Patient 1's estate plan without a letter from a physician stating that Patient 1 had the mental capacity to make legal and financial decisions. Patient 1's younger son contacted Respondent and requested that he prepare a letter attesting to Patient 1's mental status and ability to make legal and financial decisions.

16. Respondent admits that he authored and signed a letter, dated April 11, 2021, in response to the younger son's request. Respondent addressed the letter to attorney G.F., and stated that he examined Patient 1 on March 28, 2021 and April 4, 2021, and that she is suffering

from cancer of the brain, diagnosed in April 2021. The letter further states that he performed an MMSE exam on Patient 1 and her score was 29/29 and that Patient 1's ability to make legal, financial and healthcare decisions is intact. The medical records Respondent produced to the Board contain a copy of this letter, which is on the letterhead of the Department of Veteran's Affairs.[3]

17. Respondent told Board investigators that he believed the purpose of the letter he drafted and signed was merely to provide a summary of his evaluations of Patient 1 and provide clarification to her family members as to her medical status. Respondent stated that the conclusion he expressed in his April 11, 2021, letter, that Patient 1's ability to make independent legal, financial, and healthcare decisions was intact, was based on his visits with her on March 28, 2021 and April 4, 2021. He acknowledged that he did not access or obtain further medical information about Patient 1 in between his April 4, 2021, visit and his signing of the letter dated April 11, 2021. When asked how he concluded that Patient 1's decision-making ability for legal and financial matters was intact, he stated that he based his conclusion on the fact that she appeared to be improving physically, that she was able to answer basic questions about her needs, and that she expressed no concerns about her finances or her family support.

18. On or about April 16, 2021, the younger son and his sister—Respondent's mother-in-law—drove Patient 1 to attorney G.F.'s office. Attorney G.F. drafted an amendment to Patient 1's trust, revoking the prior distribution provisions of the trust, and naming the younger son as the trustee and sole beneficiary. Attorney G.F. also drafted a limited power of attorney giving the younger son authority to control Patient 1's residence and property. Finally, Attorney G.F. drafted a grant deed transferring title to the Property directly to the younger son. The parties waited at Attorney G.F.'s office until Respondent's letter reporting Patient 1's capacity to make legal and financial decisions was received by G.F. Once the letter was received, on or about

[3] The documents from the Superior Court lawsuit concerning Patient 1's estate contain a similar letter with the same content on the letterhead of Heritage Oaks Hospital, in Sacramento, also signed and dated by Respondent on April 11, 2021. Respondent was unable to explain why the two letters with different letterheads exist. He conceded that he should not have used either letterhead for the letters he authored because he did not see Patient 1 through the aegis of either Heritage Oaks or the Veteran's Affairs Administration.

April 16, 2021, Patient 1 signed the documents in favor of the younger son and the younger son recorded the grant deed.

19. After Patient 1's death, the older son who was disinherited by the April 16, 2021, amendment to the trust filed a petition challenging the validity of the amendment. The matter went to trial in Sacramento Superior Court and both the younger son and Respondent testified. Following trial, the Court found, by clear and convincing evidence, that the younger son exercised undue influence and committed elder abuse against Patient 1 by altering her estate plan in the weeks before her death. The Court concluded that Patient 1 was substantially unable to manage her financial resources or to resist fraud and undue influence. The younger son was found liable for twice the value of the property taken from the trust and was ordered to pay reasonable attorney's fees and costs.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

20. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he was grossly negligent in his care and treatment of Patient 1.

21. Paragraphs 6 through 19, above, are incorporated as if fully set forth herein.

22. Respondent was grossly negligent for his acts, including but not limited to, the following:

a. Choosing to write a letter to an attorney expressing medical opinions about Patient 1's decision-making capacity while he was involved in a dual relationship with Patient 1 and had active, non-medical relationships with Patient 1's granddaughter and other extended family members; and

b. Preparing a letter to an attorney, offering the global opinion that Patient 1 had the capacity to make legal, healthcare, and financial decisions a week after he last saw her, despite his knowledge of her recent terminal diagnosis and ongoing medical treatment, and without obtaining updated medical information, or inquiring into the specific type and purpose of the capacity inquiry.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

23. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he was repeatedly negligent in his care and treatment of Patient 1.

24. Paragraphs 6 through 19, above, are incorporated as if fully set forth herein.

25. Respondent was repeatedly negligent for his acts, including but not limited to, the following:

a. Choosing to write a letter to an attorney expressing medical opinions about Patient 1's decision-making capacity while he was involved in a dual relationship with Patient 1 and had active, non-medical relationships with Patient 1's granddaughter and other extended family members;

b. Preparing a letter to an attorney, offering the global opinion that Patient 1 had the capacity to make legal, healthcare, and financial decisions a week after he last saw her, despite his knowledge of her recent terminal diagnosis and ongoing medical treatment, and without obtaining updated medical information, or inquiring into the specific type and purpose of the capacity inquiry; and

c. Opining as to Patient 1's capacity to make decisions related to her healthcare, finances and/or legal matters without evaluating Patient 1's ability to manipulate information related to those decisions or conducting a thorough evaluation of her cognition.

THIRD CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

26. Respondent's license is subject to disciplinary action under section 2234, of the Code, in that he committed acts constituting general unprofessional conduct as alleged in Paragraphs 6 through 19, above, which are incorporated as if fully set forth herein.

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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 Number G 75437, issued to Respondent Donald Myron Hilty, M.D.;

2. Revoking, suspending or denying approval of Respondent Donald Myron Hilty, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Donald Myron Hilty, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: DEC 19 2024

REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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