

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

In the Matter of the Accusation Against:)
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)

JAMES H.I. BICHER, M.D.)

File No. 04-2000-114479

Physician's and Surgeon's)
Certificate No. A 37798)
)

Respondent.)
_____)

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on September 30, 2004.

IT IS SO ORDERED August 31, 2004.

MEDICAL BOARD OF CALIFORNIA

By: *Lorie Rice*
Lorie G. Rice, Chair
Panel A
Division of Medical Quality

**BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the Accusation Against:

**JAMES H. I. BICHER, M.D.
12099 W. Washington Boulevard, #304
Los Angeles, CA 90066**

**Physician's and Surgeon's Certificate
Number A 37798,**

Respondent.

Case No. 04-2000-114479

OAH No. L2003030214

PROPOSED DECISION

This matter came on regularly for hearing on March 23, 24, 25, 26, 30, 2004, April 1, 2, 14, 15, 16, 2004, June 16, 2004, and July 6 and 7, 2004, in Los Angeles, California, before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California.

Complainant, Ron Joseph ("Complainant"), was represented by Cindy M. Lopez, Deputy Attorney General.

Respondent, James H. I. Bicher, M.D. ("Respondent"), was present and was represented by Henry R. Fenton, Attorney at Law.

During the hearing, Complainant amended the Accusation by striking all allegations regarding patients' lack of informed consent.

Oral and documentary evidence was received. The record was held open until July 22, 2004, at which time it was closed and the matter was deemed submitted for decision.

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FACTUAL FINDINGS

The Administrative Law Judge makes the following Factual Findings:

1. Ron Joseph made the Accusation and Supplemental Accusation in his official capacity as Executive Director of the Medical Board of California ("the Board").

2. On December 12, 1981, the Board issued Physician and Surgeon Certificate No. A 37798 to Respondent. The license will expire on May 31, 2005 unless renewed.

3. This case involves Respondent's care and treatment of two terminally ill cancer patients whom he treated with radiation and hyperthermia. One of the patients suffered from metastatic breast cancer; the other, from metastatic colo-rectal cancer.

Dr. Bicher

4. Respondent is an expert in the fields of radiation oncology and hyperthermia. Born in Argentina in 1937, he attended medical school in Buenos Aires and Jerusalem. After interning in Israel, he served residencies in radiation therapy at the University of Arkansas for Medical Sciences in Little Rock, Arkansas, and at Roswell Park Memorial Institute in Buffalo, New York.

5. Respondent is the founder and Director of Valley Cancer Institute in Los Angeles. He has formerly served as Chief of the Hyperthermic Clinic at the Western Tumor Medical Group in Van Nuys, California, former Director of Non-Ionizing Radiation, Cancer Treatment Center at Henry Ford Hospital in Detroit, Michigan, and Associate Chief of the Department of Radiation Medicine at Roswell Park Memorial Institute in Buffalo, New York. He is a former Associate Professor of Pharmacology at the University of Arkansas for Medical Sciences in Little Rock, Arkansas, former Associate Professor of Anatomy and Research Medicine at the Medical University of South Carolina in Charleston, former Assistant Professor of Anatomy at the same institution, Clinical Associate Professor in Radiology at the State University of New York, and Associate Professor in the Department of Biology at Wayne State University in Detroit, Michigan.

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6. Respondent is a member of the American Society of Therapeutic Radiologists, American Microcirculatory Society, European Society of Microcirculation, International Society on Oxygen Transport of Tissue (also past president), North American Hyperthermia Group (also founder and past president), European Society of Hyperthermic Oncology (and a founding member), Radiation Research Society, Western Hyperthermia Group (also its founder), and the American Society of Clinical Hyperthermic Oncology (also its founder and a past president). Respondent holds several medically related patents and he has authored approximately 210 publications.

7. Respondent claims to be the only physician in southern California who treats malignancies with daily hyperthermia treatments and fractionalized radiation. He is deeply dedicated to his patients, and to the practice and advancement of medicine.

Prior Discipline

8. Respondent's physician and surgeon's certificate has been previously disciplined. On July 2, 1993, an Accusation was filed against Respondent¹, which was followed by a Supplemental Accusation on December 16, 1994. Several of the allegations in those pleadings, and issues relating to them, were substantially similar to those in the instant case. The matter was heard by an Administrative Law Judge with the Office of Administrative Hearings in April and September of 1995. The Board adopted the Administrative Law Judge's Proposed Decision, in which he recommended a stayed revocation with five years probation under various terms and conditions. Respondent petitioned the Superior Court for a Writ of Mandate, which resulted in the matter being remanded to the Board on November 18, 1996. On January 3, 1997, the Board issued a Decision After Remand. Petitioner subsequently filed a second Petition for Writ of Mandate. The case settled while that matter was pending.

9. Pursuant to the terms of the settlement agreement, Respondent's license was revoked. The revocation was stayed and Respondent was placed on probation for a period of 18 months under various terms and conditions. The Board adopted the Stipulated Settlement and Disciplinary Order on June 24, 1997 with an effective date of December 29, 1995. Thus, the 18-month probationary period ran prior to the settlement agreement's adoption and Respondent was not required to remain on probation after the adoption occurred.

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¹ *In the Matter of the Accusation Against James Haim Isidoro Bicher, M.D.*, Case No. D-5288, OAH No. L-63535.

The Experts

10. Each of the experts who testified in this case was eminently qualified in his field. However, each expert brought to the hearing a particular orientation and viewpoint with respect to the proper use of radiation and hyperthermia in the treatment of cancer. Those orientations and viewpoints resulted in each expert's opinions falling into one of two "camps," one of which found Respondent's care and treatment appropriate for the two patients in question, and the other of which found the opposite. For the reasons explained below, the experts espousing Respondent's care and treatment as inappropriate and below the standard of care is deemed the more credible.

11. Complainant offered the expert testimony of Zbigniew Petrovich, M.D., a radiation oncologist, certified by the American Board of Radiology since 1971, and licensed in California since 1974. Dr. Petrovich formed the Department of Radiation Oncology at the University of Southern California ("USC"), where he served as the Albert Soiland Professor of Radiation Oncology, the Albert Soiland Professor of Radiation Oncology and Urology, and Chairman of the Department of Radiation Oncology. Following his retirement from USC earlier this year, he was granted the title of Professor Emeritus in Radiation Oncology. Dr. Petrovich has also served as an Adjunct Assistant Professor, Associate Professor and Vice-Chairman of the UCLA School of Medicine Department of Radiation Oncology. His numerous other appointments include Chief of the Veterans Administration Radiation Therapy Referral & Consultation Center for the Western United States, Director of the Wadsworth Medical Center Residency Program in Radiation Therapy, Director of the USC Residency Program in Radiation Oncology, and Director of the Cancer Program at California Hospital Medical Center in Los Angeles.

12. Dr. Petrovich has been and/or continues to be a member of the Los Angeles Radiological Society, California Radiological Society, Southern California Radiation Therapy Society, California Radiation Therapy Society, American College of Radiology, American College of Radiation Oncology, American Society of Therapeutic Radiologists, American Radium Society, Radiological Society of North America, European Society for Therapeutic Radiology and Oncology, and North American Hyperthermia Society. Dr. Petrovich has won numerous honors, has served on dozens of prestigious committees, and, like Respondent, has authored hundreds of publications. Each of Dr. Petrovich's approximately 150 articles appeared in peer reviewed journals. He has served as an article reviewer for Lancet. Over the past 25 years, he has been a guest lecturer on approximately 297 occasions.

13. Dr. Petrovich has administered radiation to thousands of patients. He has administered hyperthermia to 150-200 patients, and has supervised others in the administration of hyperthermia treatments to 300-400 patients.

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14. Complainant also offered the expert testimony of Leonard R. Prosnitz, M.D., a radiation oncologist certified with the American Board of Radiology since 1970. Trained at State University of New York, Dartmouth and Yale, Dr. Prosnitz is presently a Professor in the Department of Radiation Oncology at Duke University Medical Center in Durham, North Carolina, and is past Chairman of that department. He is also a former Director of Radiation Oncology at the Veterans Administration Hospital in Durham. He continues to be an attending physician at that hospital and at Durham Regional Hospital. Dr. Prosnitz is a former Professor of Therapeutic Radiology at Yale University, and Attending Radiologist at Yale-New Haven Hospital and the Veterans Administration Hospital in New Haven, Connecticut. In 1997, the L.R. Prosnitz Chair in Radiation Oncology at Duke University Medical Center was established in Dr. Prosnitz's honor.

15. Dr. Prosnitz is the former President of the Society of Chairmen of Academic Radiation Oncology Programs and the North American Hyperthermia Society. He is a fellow in the American College of Radiology, and the author of numerous publications.

16. Respondent offered the expert testimony of A. M. Nisar Syed, M.D. Trained in India and the United Kingdom, Dr. Syed has been certified with the American Board of Radiology since 1976. He is also certified by the Royal College of Surgeons of England, F.R.C.S., Royal College of Surgeons of Edinburgh, F.R.C.S., the Royal College of Surgeons of England, D.M.R.T., and the International College of Surgeons, F.I.C.S., in the United States. He is a fellow in the American College of Radiation Oncology.

17. Dr. Syed is the Director of the Department of Radiation Oncology & Endocurietherapy at the Memorial Cancer Institute, Memorial Medical Center in Long Beach, California, a Radiation Oncologist at Saddleback Memorial Medical Center in Laguna Hills, California, an Attending Radiation Therapist at the Hospital of the Good Samaritan in Los Angeles, and an Attending Radiation Therapist at the Southern California Cancer Center of California Hospital Medical Center in Los Angeles. He was formerly an Assistant Professor in the Department of Radiation Therapy, Freeman Hospital, Howard University in Washington, D.C., and an Assistant Professor in the Department of Radiology Radiation Medicine Unit at USC School of Medicine.

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18. Dr. Syed is currently a Clinical Professor in the Department of Radiology Radiation Medicine Unit at USC School of Medicine, Clinical Professor in the Department of Radiological Sciences at the University of California at Irvine, Professor, Service Series, Department of Radiology, Charles Drew University of Medicine & Science in Los Angeles, Chancellor and Vice-Chairman of the American College of Radiation Oncology in Philadelphia, Chairman of the Radiation Oncology Committee of the Indo-American Cancer Society, and Clinical Professor in the School of Medicine, Department of Radiation Oncology, University of Kansas Medical Center. He is or has been a member of the American Society for Therapeutic Radiology and Oncology, American Radium Society, American Endocurietherapy Society, Western Association of Gynecologic Oncologists, and the American Medical Association. He is the recipient of several awards and the author of numerous publications. He is not a member of any hyperthermia societies.

19. Phillip Beron, M.D. also testified on Respondent's behalf. Dr. Beron has been board certified in radiation oncology since June of 1995. He is a member of the American College of Radiation Oncology, American Society for Therapeutic Radiology and Oncology and the American Brachytherapy Society. Dr. Beron is the Medical Director of Radiation Oncology at Good Samaritan Hospital in Los Angeles. Although he administered hyperthermia to 10 or 15 patients per year for the ten years, his primary practice is in radiation, and he does not administer any hyperthermia at the present time. He does not belong to any hyperthermia societies and has not performed any research on the subject. He is not familiar with the standards and practices of physicians outside of his own practice.

20. Respondent also offered the expert testimony of Peter Corey, Ph.D. Dr. Corey is a biophysicist at William Beaumont Hospital in Royal Oak, Michigan. He is a former full professor and acting chairman for the Department of Physics at the University of Texas at Houston.

21. Dr. Corey was involved in the early uses of hyperthermia and was the second speaker at the first international meeting on hyperthermia. He has been active in that field for many years, through, among other things, direct involvement with the National Cancer Institute and the National Institutes of Health, through which he has served on a number of advisory panels. He is the recipient of the Robinson Award from the North American Hyperthermia Society, an organization of which he is a former president. For the past approximately 15 years, Dr. Corey had been a hyperthermia consultant to the Department of Radiation Oncology at Duke University. Dr. Corey was involved with, and an author of, the guidelines for the use of hyperthermia established by the Radiation Therapy Oncology Group ("RTOG").

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Hypothermia

22. Treatment of malignant tumors tends to have better results when the treatment is given to an oxygen-rich area. Oxygen levels at the site of a tumor increase when the temperature at the site is elevated. Hyperthermia is a method of increasing oxygenation by raising the temperature at the site of a tumor. The optimum temperature during a hyperthermia treatment is 101-105 degrees Fahrenheit.

23. Two types of hyperthermia are presently in use. The type of hyperthermia administered to a patient depends on the tumor location. If the area to be treated is within 1.25 inches of the skin's surface, it may be treated with superficial hyperthermia. This is accomplished via microwaves, radio frequencies, ultrasound, or even circulating hot water. If the tumor is deep (more than 1.25 inches of the skin's surface), it must be treated with ultrasound or radio frequencies other than those used for superficial hyperthermia. 915 MHz is the most commonly used frequency for superficial hyperthermia.

24. For the effective treatment of breast cancer with hyperthermia, the temperature must be measured at the site of the tumor rather than on the skin. To that end, a catheter is placed at the tumor site and a temperature probe, such as a thermocouple, is inserted into the catheter. To ensure proper placement, an x-ray is taken or a picture is made to establish the depth and location of the probe in relation to the tumor.

25. Once the probe is in place, an apparatus called an "applicator" is positioned above the breast close to the skin. The applicator's power is adjusted to provide the correct amount of heat to maintain the proper temperature range at the tumor site. "Temperature mapping," the taking of temperatures at different sites every four minutes, occurs during the treatment. The entire process takes approximately 45-90 minutes, including the periods of time during which the temperature is rising to the correct level and is cooling at the end of the treatment.

26. The location of the temperature probe in the treatment of colon cancer depends on the size and location of the tumor. Hyperthermia is contraindicated for the treatment of lung cancer.

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27. Following a hyperthermia treatment, malignant cells develop a resistance to additional hyperthermia for a period of approximately 48 hours and tend to be less responsive to radiation treatment during that time. That resistance is called thermotolerance. Thermotolerance reduces the efficacy of radiation. Due to the risk of thermotolerance, the standard of care for the past approximately 20 years has been to give radiation treatment every day, five days per week, and hyperthermia treatment once or twice per week. According to the guidelines of the European Society of Hyperthermic Oncology and RTOG, hyperthermia treatments should not be given more frequently than every 72 hours. With very few exceptions, it should never be given more frequently than every 48 hours. Dr. Petrovich is unaware of any peer-reviewed data that supports the use of daily hyperthermia on a patient. Accordingly, Complainant asserts that the use of hyperthermia in the treatment of cancer with any greater frequency than every 48 hours, constitutes a deviation from the standard of care.

28. Respondent's experts disagree.

a. Dr. Syed testified that no consensus exists as to whether hyperthermia may properly be given on a daily basis and that, in his opinion, it may. He does not believe that a specific standard of care exists on that issue. Nonetheless, when Dr. Syed uses hyperthermia, he generally times the treatments to occur every two or three days. In his 18-20 years of experience administering hyperthermia, he has used daily treatments on no more than 5% of his patients.

b. Dr. Beron testified that, according to some of the literature, thermotolerance does not exist in every cell line (although he believes thermotolerance does exist in breast cancer), and that certain conditions in the cell such as low Ph, reduce thermotolerance, as do daily doses of radiation. Therefore, no standard of care exists with respect to the frequency of hyperthermia treatments. Dr. Beron does not presently administer hyperthermia treatment. When he did so, he timed the treatments to occur two to three times per week.

c. Dr. Corey believes the best way to administer hyperthermia is five times per week, and has advocated that approach for 15-20 years. He believes that the more heat one gives, the more effective is the radiation in killing cancer cells because of direct potentiation plus tumor reoxygenation. The additional heat causes the oxygen level to increase and the hypoxic fraction of cells to decrease, thus making the radiation more effective. Dr. Corey does not believe physicians can follow the RTOG guidelines because they are too technical. Nonetheless, Dr. Corey acknowledges that his view is a minority one among physicians who give hyperthermia treatments. At the hospital where he works, hyperthermia is given every day that radiation is given, but radiation is not given every day.

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29. Dr. Prosnitz testified that, in the clinical (as opposed to laboratory) setting, Ph levels cannot be reduced to the point to which they would have the therapeutic effect referenced by Dr. Beron.

30. Given the experts' testimony, the standard of care with respect to the timing of hyperthermia treatments during 1998 and 1999 is deemed that asserted by Complainant.

31. Respondent is deeply committed to the use of daily hyperthermia treatments, particularly in conjunction with radiation therapy, for the treatment of a variety of cancer types. He bases his convictions on a voluminous number of journal articles, treatises and the like, much of which is based on his own research, that purportedly support his views. Respondent offered a great deal of that literature at the hearing as evidence of the standard of care during the relevant time period. Upon Complainant's objection, the documents were excluded for that purpose, but were received in evidence for the purpose of establishing the basis for Respondent's beliefs and conduct.

Radiation Dosage

32. In the 1930's and 1940's, the optimal time and dosage for radiation treatment was determined. Although allowing for some variation, a 6-8 week course totaling approximately 6000 radiation units ("cGy" or "rads") was deemed optimal for breast cancer. The optimal dosage for colon cancer was approximately the same. For both types of cancer 180-200 cGy, plus or minus 10% per treatment, was determined to be the proper dose.

33. The literature does not support dosages of less than 180 cGy for breast or colon cancer because of the risk of repopulation. Repopulation occurs when cancer cells grow back during the course of treatment. If the dose of radiation per treatment is too low, the physician reaches his/her maximum of 6000 cGy without having accomplished the therapeutic goal. The physician cannot exceed 10% over 6000 units without the risk of creating what Dr. Petrovich referred to as "pretty steep complications."

34. Respondent and his experts take a contrary view. They believe the total goal (i.e., approximately 6000 cGy) can be reached with good therapeutic effect by reducing the number of rads and increasing the number of treatments by combining the radiation treatment with hyperthermia. The lower radiation dose is offset by the hyperthermia's potentiating effect. Nonetheless, Dr. Syed was unable to cite to any literature that supports that position. Further, he himself does not routinely reduce the radiation dose below 180 cGy even with hyperthermia unless the patient has received a significant amount of radiation and still has tumor.

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35. The standard timing for radiation therapy is five days per week. This is especially true when the treating physician lowers the dosage and increases the number of treatments. However, as indicated above, the standard of care does not permit the use of hyperthermia five days per week since 48-72 hours must elapse between the treatments. Therefore, a physician cannot compensate for excessively low doses of radiation with daily hyperthermia treatments. For the physician to meet the standard of care in providing radiation therapy, he/she must treat with 180-200 cGy over an approximately six to eight week period, without exceeding approximately 6000 cGy over the total course of treatment.

36. Respondent is a strong advocate of the use of radiation doses below 180 cGy for patients who have remaining tumor after some number of radiation treatments at or above 180 cGy. He favors this approach over what he terms the "dump and pray" technique of the more traditional practitioners because, with the more traditional approach, the failure to completely destroy the tumor after a full course of radiation therapy using 180-200 cGy per treatment, results in a "death sentence" (Respondent's term). In contrast, he claims that his technique enables the patient to continue to receive tumor-destroying radiation, in diminishing doses over a longer period of time, while avoiding toxicity and side effects. The weight of the evidence established that the standard of care in 1998 and 1999 was the more traditional approach of 180-200 cGy per treatment because decreasing dosages below the 180 cGy minimum are ineffective. The more effective treatment is to provide the patient with the maximum amount of tumor-destroying potential per treatment without causing collateral harm. That amount is (with certain exceptions not applicable in J.K.'s case) 180-200 cGy per treatment up to a maximum of approximately 6000 cGy for the total regimen.

Patient E.F.²

37. On April 16, 1998, patient E.F., a 51-year-old female, presented at Respondent's clinic, Valley Cancer Institute ("VCI") for consultation on a self-referral basis. Approximately one year earlier, she noted a small lump in her left breast. Because she was fearful of physicians, she self-treated with diet and supplements. Shortly before seeing Respondent, she noticed a node in the left axilla.

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² The patients' initials are used in lieu of their names in order to protect their privacy as well as that of their families.

38. Respondent performed an extensive physical examination on E.F. on April 16, 1998. However, his written history and physical was limited in scope and did not reflect the extent of his work. During his physical examination, Respondent found a large mass in the left breast which occupied most of the breast, and nodules in the chest wall. The patient was not short of breath and there was no evidence of pleural involvement. There was, however, evidence of skin involvement. The patient had previously refused all traditional treatment, including radiological studies, biopsy, radiation and chemotherapy. She had undergone one ultrasound that showed probable malignancy. Respondent convinced E.F. to undergo a needle biopsy, but even without the test results, he considered the tumor "obviously malignant." He believed E.F. required immediate palliative treatment but, because she refused radiation and because he did not yet have histological proof, he started her on hyperthermia alone.

39. Dr. Petrovich testified that Respondent's treating E.F. with hyperthermia alone, and his treating her with hyperthermia in the absence of a definitive diagnosis, each constituted a simple departure from the standard of care. However, he also testified that hyperthermia alone may safely be used in the treatment of benign tumors. Temporary treatment with hyperthermia alone, until a definitive diagnosis could be made, would cause no harm and could have some small palliative effect. However, it also presented a risk of early regeneration of malignant cells. Therefore, in light of the circumstances under which Respondent began his treatment of E.F., Respondent's treatment of E.F. using hyperthermia alone constituted a simple departure from the standard of care.

40. Respondent prepared a treatment plan dated April 16, 1998. That treatment plan included a hand-drawn chart showing the intended placement of thermocouples in three different fields to measure tumor temperature. However, according to the chart, both microwave and ultrasound hyperthermia were to be used without differentiation as to which mode would be used in the specific fields. In addition, the chart did not indicate whether the thermocouples were to be placed on or under the skin or, if under the skin, the depth to which they were to be inserted. Respondent's failure to properly indicate the location of the temperature probes used in the hyperthermia treatments constituted an extreme departure from the standard of care, and a failure to maintain adequate and accurate records.

41. Respondent's failure to indicate the precise location of the thermocouples notwithstanding, he was credible in his testimony that he placed two thermocouples in each field, one on the skin and the other beneath it. That testimony was corroborated by the charts generated by the treatment apparatus indicating treatment within the correct temperature range and at a level warmer than would have been indicated had the thermocouple been placed on the skin only. In light of those records, testimony by E.F.'s sister that E.F. was afraid of needles (necessary for the placement of thermocouples under the skin), and that she did not see bandages on E.F.'s skin, was not sufficient to raise an inference that the thermocouples were not inserted beneath the skin.

42. The biopsy was performed on April 29, 1998 and it confirmed the diagnosis of cancer. E.F. agreed to a course of radiation treatments in conjunction with hyperthermia. The treatments were performed on a daily basis. On certain days, E.F. underwent two hyperthermia treatments, but each such treatment was given to a disparate field.

43. Respondent's treating E.F. with daily hyperthermia constituted an extreme departure from the standard of care.

44. By May 5, 1998, the skin at the left lateral abdomen was involved. On that and the following day, Respondent administered radiation and hyperthermia treatments to that area. Complainant failed to sustain his burden of proof that Respondent fell below the standard of care by treating the left lateral abdomen. However, Respondent failed to document the existence of left lateral abdomen involvement or the need for treatment in that area. That omission constituted a failure to maintain adequate and accurate records.

45. On May 7, 1998, E.F. reported progressive shortness of breath over the past several days. Respondent found pleural effusion which was the result of the breast tumor invading the lung through the chest wall. E.F. refused chemotherapy and thoracentesis at that time. Respondent began E.F. on a course of radiation treatment with superficial hyperthermia to the anterior mediastinum and right and left lower chest wall. He did not treat the lungs with radiation and hyperthermia. A CT scan of the chest taken on May 13, 1998, confirmed large pleural effusion on the left and right. Complainant failed to sustain his burden of proof that the pleural effusion was manifested at the time of E.F.'s April 16, 1998 physical examination.

46. The posterior mediastinum also required treatment. Superficial hyperthermia to that area would have been ineffective, and ultrasound hyperthermia would have overheated the bone, causing pain. Therefore, Respondent recommended radiation without hyperthermia for the posterior mediastinum. The patient refused that treatment.

47. Treating the anterior mediastinum and right and left lower chest wall with superficial hyperthermia and radiation was within the standard of care. Respondent did not sustain his burden of proof that Respondent treated the patient's right lower and left lower lung areas with radiation and hyperthermia to control her pleural effusion, or that he treated the pleural effusion with radiation and hyperthermia.

48. Respondent subsequently convinced E.F. to undergo a thoracentesis to drain the fluid, and one chemotherapy treatment to treat the metastatic growth at the pleura. The thoracentesis occurred on June 1, 1998 with good results. However, the pleural effusion returned and E.F. refused additional chemotherapy.

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49. By June 12, 1998, E.F.'s breast tumor was 95% resolved. She continued to undergo daily treatment with radiation and hyperthermia. On certain days, hyperthermia was given without radiation. At the hearing, Respondent claimed, but failed to establish, that the lack of concurrent radiation treatments with hyperthermia was due either to the patient's refusal to undergo the radiation treatment after receiving the hyperthermia, or because of technical problems. Unlike the hyperthermia treatments he administered to E.F. while he was awaiting the test results with which he would render a definitive diagnosis, given the limited amount of radiation a patient can safely tolerate, and the increased resistance to radiation caused by thermotolerance, Respondent's periodic use of hyperthermia alone during the main course of her treatment constituted an extreme departure from the standard of care.

50. The marked improvement in the breast tumor notwithstanding, the cancer had metastasized into the lungs. E.F. expired on August 31, 1998.

51. Throughout the treatment, Respondent had been honest with E.F., explaining to her the details of her therapy, the fact that the cancer was metastasizing, and her prognosis. He told her he was optimistic about the prognosis for the breast tumor. That prognosis proved to be accurate. Complainant failed to sustain his burden of proof that Respondent gave false information to E.F.

52. During the course of E.F.'s treatment, Respondent took some, but an inadequate number of Port films of the various treatment fields. He also failed to take Port films that included the chest wall, claiming that E.F.'s treatment was palliative and that there was no point in doing additional harm under those circumstances. That argument is unconvincing. The same could be said for all Port films. The standard of care is no different with respect to the areas of which Port films must be taken in the course of palliative treatment than it is in the course of curative treatment. Respondent's failure to take an adequate number of Port films, and his failure to take Port films that included the chest wall, each constituted a simple departure from the standard of care. However, despite Respondent's late delivery of additional Port films in response to Complainant's discovery request, Complainant did not sustain his burden of proof that Respondent failed to make Port films a part of E.F.'s records during the course of her treatment.

53. Several treatment records, reflecting various individual hyperthermia treatments, were generated by the hyperthermia apparatus. However, many of those records were not printed and placed into E.F.'s chart. It was not until this action had commenced that the records were retrieved from a diskette and printed. A few of the records are still missing. The failure to print those records and place them into E.F.'s chart constituted a failure to maintain adequate and accurate records.

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54. In 1998, it was Respondent's custom and practice to give hyperthermia treatments on weekdays, but not weekends. During her treatment with Respondent between April 16, 1998 and July 7, 1998, E.F. received 18 hyperthermia treatments to the left medial breast, 14 hyperthermia treatments to the left lateral breast, 23 hyperthermia treatments to the mediastinum, 2 hyperthermia treatments to the left lateral abdomen, 33 hyperthermia treatments to the right lower chest wall, and 15 hyperthermia treatments to the left lower chest wall. Periods of daily treatment to the same field (except for weekends) included April 17-21 (left lateral breast), April 20-May 6 (left medial breast), April 24-28 (left lateral breast), April 30-May 4 (left lateral breast), May 12-13 (left medial breast), May 7-8 (mediastinum), May 11-12 (right lower chest wall), May 13-19 (mediastinum), May 21-22 (mediastinum), May 27-June 11 (right lower chest wall), June 3-15 (mediastinum), June 18-July 7 (left lower chest wall), and June 19-July 7 (right lower chest wall). As stated above, the daily hyperthermia treatments constituted an extreme departure from the standard of care.

Patient J.K.

55. Complainant established the allegations contained in Paragraphs 29 through 36 of the Accusation. Those paragraphs are repeated verbatim below, and are incorporated as factual findings herein.

29. On or about October 27, 1998, patient J.K., a male patient who was 61 years old at the time, presented to VCI with a carcinoma of the colon-rectum (i.e., a common cancerous tumor of the rectum and colon) with progressive non-resectable locoregional disease in the pelvis. The patient had previously undergone a colon resection procedure in July of 1997, and had a second surgical procedure in early 1998 with a partial tumor resection and the establishment of a diverting colostomy. Also in early 1998, and following the second procedure, the patient consulted with Chester Gottlieb, M.D., a medical oncologist, who opined the J.K. had an incurable tumor. Although the patient was initially seen by Ralph Wolfstein, M.D., a VCI doctor, when he first presented at VCI in October of 1998, Respondent assumed responsibility for the overall management of the patient's care.

30. Patient J.K.'s medical records reflect that progress notes were made for approximately twenty-seven (27) visits following J.K.'s initial consultation, with Respondent the treating doctor on approximately sixteen (16) dates, the last time on or about November 7, 1999. However, the patient's treatment history reflects that the patient made many more visits for treatment.

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31. During the course of his therapy, the patient received a very high dose of radiation treatments totaling 8015 cGy³ over eighty (80) sessions occurring over a period of one-hundred and [sic] ninety-eight (198) days. The pelvis was treated with anterior (i.e., frontal) and perineal (i.e., from below) fields. Radiotherapy was given at 180 cGy for the first six (6) treatments, decreased to 150 cGy per day for fourteen (14) sessions, decreased to 120 cGy daily for twenty-seven (27) treatments, decreased to 50 cGy per day for twenty-seven (27) sessions, and further decreased to 25 cGy daily. The radiation was applied using antero-posterior and perineal fields.

32. During the course of this therapy, the patient also received radiotherapy to his T-10 through S-2 areas⁴ with a total dose of 4840 cGy in thirty-three (33) sessions given over fifty-nine (59) days between and including September 13, 1999 and November 15, 1999.

33. During the course of treatment at VCI, the patient also received spinal radiotherapy at 180 cGy daily for ten (10) sessions, at 150 cGy for ten (10) sessions, at 120 cGy for eight (8) daily sessions, and at 100 cGy for three (3) daily sessions.

34. During the course of treatment at VCI, the patient was also given hyperthermia treatment of 915 MHz microwaves over one-hundred [sic] thirty-three (133) sessions to the pelvis and twenty-nine (29) to the spine (T-10 to sacrum). Temperature measurements during hyperthermia sessions were noted without information regarding the exact location of the temperature probes used. Three temperature probes were used for the duration of each treatment. The length of treatment sessions varied widely from thirty (30) to ninety (90) minutes.

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³ "cGy" is a unit of radiation dose.'

⁴ "T" represents the thoracic spine; "S" represents the sacral spine.'

35. On the patient's treatment summary, a partial response to the thermoradiotherapy⁵ treatments was noted, but no objective evidence of such a response was documented. The patient's records also showed a progressive elevation of tumor markers⁶ from December 2, 1998 through November 8, 1999, indicating that the patient's disease was progressing. In June of 1999, Dr. Wolfstein noted his concern that the patient was developing rectal bleeding. The patient was reassured by Respondent despite this finding and the increased tumor markers. In September of 1999, the patient was experiencing pain in both buttocks. Respondent thereafter had a "long conversation for reassurance" with J.K. In November of 1999, despite the patient's renal dialysis and difficulty in ambulating, Respondent noted that the "patient is doing well." From November of 1999 through December of 1999, the patient's condition continued to deteriorate, with symptoms of progressive uremia and anemia, progressive renal (kidney) failure, and progressive cancer. The patient died from these complications on January 1, 2000.

36. Both the hyperthermia and radiation treatments were given with Respondent listed in the patient's medical records as the "physician in charge."

56. J.K.'s tumor decreased in size by at least 50% before his death. It remained at its smaller size until J.K. died. Respondent considered that a "partial response."

57. As in E.F.'s case, early in J.K.'s treatment, Respondent prepared a treatment plan for J.K. That treatment plan included a hand-drawn chart showing the intended placement of thermocouples in the treatment fields to measure tumor temperature. However, the chart did not indicate whether the thermocouples were to be placed on or under the skin or, if under the skin, the depth to which they were to be inserted. Respondent's failure to properly indicate the location of the temperature probes used in the hyperthermia treatments constituted an extreme departure from the standard of care, and a failure to maintain adequate and accurate records.

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⁵ 'Thermoradiotherapy means the combination of heat and radiation treatment.'

⁶ 'Tumor markers are chemicals in the blood which, when analyzed, may reflect whether a tumor is progressing or regressing.'

58. Respondent used a time dose fractionation formula to determine the radiation dosage for J.K.'s treatment. He strongly believes that the formula he used resulted in the "equivalent" (Respondent's term) of 6000-6700 cGy, even though the total was actually 8015 cGy. James Gonzalez, the medical physicist who utilized the formula to determine the dosage and number of treatments, provided his services only to Respondent and, to a much smaller extent, one other clinic. Respondent is the only physician with whom he has worked who gives radiation treatments at under 100 cGy. It has been his experience that the standard or typical treatment for breast cancer is 28 "fractions" (treatments) at 180 cGy over approximately 5 weeks, and approximately the same or slightly more for colo-rectal cancer. In his experience, 8-10 weeks of radiation is above the norm.

59. Respondent administered an excessive total radiation dose to J.K. over an excessive number of treatments. His doing so constituted an extreme departure from the standard of care.

60. Over the course of J.K.'s treatment, Respondent decreased the radiation dose per treatment to well below the necessary 180-200 cGy. His doing so constituted an extreme departure from the standard of care.⁷

61. Over the course of J.K.'s treatment, Respondent administered an excessive number of hyperthermia treatments. His doing so constituted an extreme departure from the standard of care.

62. On February 17, 1999, Respondent ordered J.K.'s radiation treatments temporarily stopped and hyperthermia given alone for a period of two weeks. The circumstances under which Respondent treated J.K. with hyperthermia alone were far different from those he initially faced with E.F. In J.K.'s case, the use of hyperthermia alone posed the risk of diminishing the efficacy of the limited amount of radiation the patient could safely tolerate due to the effect of thermotolerance. Respondent's administration of hyperthermia alone constituted an extreme departure from the standard of care.

63. The pelvis was one of the fields which Respondent treated with radiation and hyperthermia. Respondent used ultrasound (deep) hyperthermia for that purpose. Complainant failed to sustain his burden of proof that Respondent used a superficial level of hyperthermia for a deep pelvic lesion.

64. Respondent treated J.K.'s spine with superficial (microwave) hyperthermia. Complainant failed to sustain his burden of proof that do so was below the standard of care.

⁷ Dr. Petrovich described the length of J.K.'s radiation treatment and the dosages below 180 cGy as "unprecedented."

65. Although Complainant sustained his burden of proof that Respondent used inappropriate radiotherapy doses relative to the patient's condition, he failed to sustain his burden of proof that Respondent deviated from the standard of care by using anterior-posterior and posterior-anterior fields.

66. Respondent failed to properly document some of the radiotherapy and hyperthermia treatments J.K. received. That failure constituted a simple departure from the standard of care and a failure to maintain adequate and accurate records.

67. Respondent took a number of Port films of the affected fields during the course of J.K.'s treatment. He used blocks to prevent an overlap of radiation which could occur in the process of making the films. Complainant failed to sustain his burden of proof that the Port films were inappropriate. However, Respondent failed to take a sufficient number of Port films over the course of the treatment to satisfy the standard of care. His failure to do so constituted a simple departure from the standard of care.

68. Respondent believes he saw the patient on a daily basis, but only charted a visit every couple of weeks. Respondent's failure to properly chart his patient visits constituted a simple departure from the standard of care and a failure to maintain adequate and accurate records.

69. During the course of treatment, several treatment records generated by the hyperthermia apparatus were not printed and placed into J.K.'s chart. It was not until this action had commenced that the records were retrieved from a diskette and printed. A few of the records are still missing. The failure to print those records and place them into J.K.'s chart constituted a failure to maintain adequate and accurate records.

70. Complainant failed to sustain his burden of proof that Respondent gave "false information to the patient in the face of overwhelming evidence of tumor progression." (Supplemental Accusation, paragraph 41(J).) Respondent provided reassurance to J.K. whose medical condition and prognosis were grave. However, the evidence did not establish that anything Respondent said to J.K. was false.

Statements on the Website

71. In 1998, the VCI website contained several representations about VCI, and about hyperthermia as a treatment for cancer. Among those representations were the following: (1) VCI is one of the largest non-profit hyperthermic research and patient treatment centers in the United States, (2) the lungs are treatable with hyperthermia, (3) hyperthermia is effective on its own, and (4) anyone at any age can receive hyperthermia treatments.

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72. VCI operates five hyperthermia machines in an approximately 12,000 square foot facility. Far more patients are treated with hyperthermia at VCI than at the next largest hyperthermia facility (probably the University of Southern California or Duke University). Given the number of hyperthermia machines used, the size of the facility, the number of patients treated at the facility, and Respondent's extensive body of research, Complainant failed to sustain his burden of proof that Respondent's claim about VCI's size and purpose was a misrepresentation.

73. Hyperthermia is not used for cancer in the lungs because microwaves cannot penetrate far enough, and ultrasound would be painful, and possibly fatal, to the patient.

74. There was testimony at the hearing that hyperthermia, used alone for palliative treatment, has shown some positive results. However, it is not deemed "highly effective" because malignant cells tend to return quickly to the tumor site following the hyperthermia treatment.

75. It is not true that anyone at any age may receive hyperthermia treatment. Hyperthermia is contraindicated in certain situations.

76. Complainant sustained his burden of proof that the representations on the VCI website that (1) the lungs are treatable with hyperthermia, (2) that hyperthermia is effective on its own, and (3) that anyone at any age can receive hyperthermia treatments, were false. Those misrepresentations constituted false or misleading advertising.

Factors in Mitigation and Aggravation

77. Since his prior discipline, Respondent improved his practice by adding a medical oncologist to his staff, spending more time "patrolling" (Respondent's term) the hyperthermia area of his clinic visiting patients during their treatment, improving his charting both in radiation and hyperthermia, and placing more detailed notes in the chart. All charts are more complete than they had previously been.

78. Respondent has not changed his predilection for providing hyperthermia on a daily basis. However, he now tries to assess the treatment and response more objectively through the use of tumor markers, CT scans, MRI's, and PET scans.

79. Approximately three years ago, Respondent became more careful in monitoring the placement of thermocouples and making better diagrams of those placements. He also began making "pictures" (Respondent's term), but not x-rays, of the temperature probe placements, and began recording the depth of temperature probe insertion on the patients' charts. He now makes pictures and takes x-rays to ensure proper thermocouple placement. He carries out those procedures in approximately 90% of his cases.

80. Respondent has helped a great number of individuals recover from malignant tumors and/or enjoy a better quality of life while suffering with cancer. However, he is realistic about his skills and techniques. Hyperthermia is a relatively new treatment modality, having gotten its start after World War II. Recognizing that there are only approximately 15 major hyperthermia centers in the world⁸, Respondent acknowledges that he has had both successes and failures and that, in practicing hyperthermia as he does, he may be wrong and he may be right. He realizes that he cannot cure every patient, regardless of the techniques he employs, but he prides himself on his ability to extend his patients' lives and improve the quality of their lives. As he said with respect to Patient J.K., "I didn't win the war but I lost it slowly."

Costs

81. Pursuant to Business and Professions Code section 125.3, Complainant's counsel requested that Respondent be ordered to pay to the Board \$25,283.95 for its costs of investigation and prosecution of the case. The costs consist of \$2,949.95 for investigative services, \$4,050.00 for expert witness fees, and \$18,284.00 in Attorney General's fees. The investigative services costs and expert witness fees are deemed just and reasonable.

82. On February 6, 2004, the Administrative Law Judge issued his Prehearing Conference Order. Paragraph 6 of that Order read as follows:

Complainant's counsel is specifically ordered to exchange discovery documents relating to the request to recover costs (e.g., a preliminary certified copy of the actual costs or good faith estimate, declarations, billings/invoices, and/or time sheets relating to costs claimed and time charged by investigators, paralegals, counsel, experts and consultants) by 5:00 p.m. on March 8, 2004.

83. Complainant's counsel failed to comply with Paragraph 6 of the Prehearing Conference Order.

84. California Code of Regulations, title 1, section 1042, subdivision (c) states:

At the Hearing, the evidence related to costs shall be presented by the agency before conclusion of its case in chief.

85. Complainant concluded his case in chief on March 26, 2004. The certification of costs for Attorney General fees was not offered on or before that date.

⁸ Respondent explained that, of those 15 centers worldwide, only 5-6 are located in the United States, and only 2-3 are in California.

86. On May 7, 2004, the Certification of Costs: Declaration of Cindy M. Lopez, dated May 7, 2004, was faxed to the Administrative Law Judge. It reflected fees charged by three Deputies Attorney General, without reference to the tasks performed by each of them or the reasons three attorneys were assigned to work on the case.

87. At the hearing, the Deputy Attorney General assigned as trial counsel stated that she had overlooked the mandates of the Prehearing Conference Order and California Code of Regulations, title 1, section 1042, subdivision (c) with respect to submission of the cost declaration for Attorney General fees.

88. Complainant failed to comply with the cost recovery requirements of the Prehearing Conference Order and California Code of Regulations, title 1, section 1042, subdivision (c), without good cause. The request for Attorney General fees is denied.

89. Although Complainant failed to prevail on the causes for discipline relating to incompetence, the nature and extent of the investigative and expert witness services is not deemed to have been any more extensive than it would otherwise have been, absent those causes for discipline. Accordingly, no allocation is necessary. Complainant shall recover \$6,999.95 for his costs of investigative and expert witness services.

LEGAL CONCLUSIONS

Pursuant to the foregoing Factual Findings, the Administrative Law Judge makes the following legal conclusions:

1. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (b), for gross negligence, as set forth in Findings 22 through 36, 37, 38, 40, 42, 43, 49, 54, 55, 57, 59, 60, 61 and 62.

2. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c), for repeated negligent acts, as set forth in Findings 22 through 36, 37 through 40, 42, 43, 49, 52, 54, 55, 57, 59 through 62, and 66 through 68.

3. Cause does not exist to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (d), for incompetence, as set forth in Findings 4 through 7, 22 through 36, 37 through 42, 44 through 49, 51, 52, 54, 55, 57 through 67, 70, and 77 through 80.

4. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2266, for failure to maintain adequate and accurate records, as set forth in Findings 37, 38, 40, 44, 53, 57 and 69.

5. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2271 in conjunction with Business and Professions Code section 17500, for false or misleading advertising, as set forth in Findings 71, 73, 74, 75 and 76.

6. Cause exists to order Respondent to pay the costs claimed under Business and Professions Code section 125.3, as set forth in Findings 81 through 89.

It is difficult to determine whether, in 1998 and 1999, Respondent was a pioneer or a renegade in his field. What can be determined is that he fell below the standard of care in connection with his care and treatment of patients E.F. and J.K.

What can also be determined is that Respondent was not incompetent. He was (and is) a renowned expert in the field of radiation oncology. He was (and is) well aware of the various approaches to the use of hyperthermia and correct dose determination for radiation therapy. He chose to treat his patients in a manner consistent with the results of his research and that of others whose research yielded similar results.

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The technical term "incompetency" is a relative one generally used in a variety of factual contexts to indicate an absence of qualification, ability or fitness to perform a prescribed duty or function. (Citations.) It is commonly defined to mean a general lack of present ability to perform a given duty as distinguished from inability to perform such duty as a result of mere neglect or omission. (Footnote omitted.) Such an interpretation is totally consistent with the declared legislative objective of public protection by requiring a minimum standard of professional conduct on the part of those licensed to engage in regulated activities. (Citation.) . . . the terms negligence and incompetency are not synonymous; a licensee may be competent or capable of performing a given duty but negligent in performing that duty. This fundamental conceptual distinction has long been recognized in California law (Citations) and in other jurisdictions (Citations.) In defining a similar operative term in the context of an employer's liability for injury caused by an 'incompetent' employee, our state Supreme Court has emphasized that basic distinction in explaining that 'Incompetency connotes the converse of reliability . . .' (Citation) and that 'a single act of negligence . . . may be attributable to remissness in discharging known duties, rather than . . . incompetency respecting the proper performance.' (*Peters v. Southern Pacific Co., supra*, at p. 62⁹.) The Legislature has consistently acknowledged that basic distinction in enacting and amending a number of regulatory statutes authorizing sanctions for either incompetence or negligence (Footnote omitted.) Thusly, to construe the one as merely synonymous with the other is inconsistent with general principles of construction requiring that meaning and effect be accorded to all of the statutory parts and that an interpretation of a statute be avoided which renders some of its words surplus. (Citations.)

Pollak v. Kinder (1978) 85 Cal.App.3d 833, 837-838, 149 Cal.Rptr. 787.

Respondent deviated from the standard of care. In the language of *Peters v. Southern Pacific Co., supra*, he was remiss in discharging known duties. But he was not incompetent.

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⁹ *Peters v. Southern Pacific Co.* (1911) 160 Cal. 48, 116 P. 400.

Complainant argued that, given the nature of his wrongdoing, and the fact that he suffered earlier discipline for similar violations of the Medical Practice Act, Respondent's license should be revoked. Under other circumstances, that argument might be more compelling. However, this case carries some unique characteristics that warrant careful consideration in fashioning a disciplinary order. For example, pursuant to the settlement agreement in the earlier case, Respondent's 18-month probationary period was served retroactively. Accordingly, neither Respondent, the Board, nor the public reaped the benefits normally associated with a probationary certificate, and the purpose of the disciplinary order was not fully realized. Further, Respondent has changed his practice for the better since his earlier discipline, even though he has not completely addressed all of the problem areas that led to both of the disciplinary actions against him.

Finally, even though Respondent deviated from the standard of care in connection with patients E.F. and J.K., his methods were not necessarily clinically "incorrect." Both patients were suffering from metastatic cancer and were terminal when they presented. Under Respondent's care, one patient experienced a 95% resolution of the original tumor; the other, a 50% resolution. The weight of the evidence determined the standard of care in Respondent's geographic area during the relevant time period, but not the efficacy of Respondent's treatment methods. Although the two patients whose care and treatment were the subject of this action did not survive, a great many others have, some of whom testified at the hearing as to their remarkable stories of recovery.

It is axiomatic that the standard of care is a fluid concept that shares a symbiotic and inter-dependent relationship with medical progress. Only time will tell whether Respondent is a pioneer or a renegade. He deviated from the standard of care in his treatment methods, and for that, his license is disciplined. However, revocation would be punitive. The public health, safety and interest should be adequately protected by the issuance of a properly conditioned probationary certificate.

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ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Certificate No. A 37798, issued to Respondent, James H. I. Bicher, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years upon the following terms and conditions.

1. Within 15 days after the effective date of this decision, Respondent shall provide the Division, or its designee, proof of service that Respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent or at any other facility where Respondent engages in the practice of medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to Respondent.

This condition shall apply to any change(s) in hospitals, other facilities, or insurance carriers.

2. 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.

3. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, 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.

4. Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of Respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Respondent shall not engage in the practice of medicine in Respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

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5. Respondent shall be available in person for interviews either at Respondent's place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

6. In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California 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; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if Respondent's periods of temporary or permanent residence or practice outside California totals two years. However Respondent's license shall not be cancelled as long as Respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

7. In the event Respondent resides in the State of California and for any reason Respondent stops practicing medicine in California, Respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve Respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if Respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

8. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Division, 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 Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

9. Within 90 calendar days from the effective date of the Decision or other period agreed to by the Division or its designee, Respondent shall reimburse the Division the amount of \$6,999.95 for its investigative and expert witness costs. The filing of bankruptcy or period of non-practice by Respondent shall not relieve Respondent of his obligation to reimburse the Division for its costs.

10. Following the effective date of this Decision, if Respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request the voluntary surrender of his license. The Division reserves the right to evaluate Respondent's request and to exercise its discretion 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 his wallet and wall certificate to the Division or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of Respondent's license shall be deemed disciplinary action. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

11. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

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12. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Division 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 preferably are American Board of Medical Specialties (ABMS) certified. 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 Division, 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 Division or its designee shall provide the approved monitor with copies of the Decision(s) and Accusations, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusations, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusations, 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.

Within 60 calendar days of the effective date of this Decision, 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.

The monitor shall submit a quarterly written report to the Division 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.

It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Division 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 5 calendar days of such resignation or unavailability, submit to the Division 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 days of the resignation or unavailability of the monitor, Respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

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In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, 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.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

13. Within 60 calendar days of the effective date of this decision, Respondent shall enroll in a course in medical record keeping, at Respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

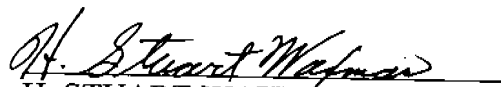
A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved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

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

15. Within 30 calendar days of the effective date of this Decision, Respondent shall delete from the VCI website all of the misrepresentations referenced in Findings 71, 73, 74, 75 and 76, above.

16. Upon successful completion of probation, Respondent's certificate shall be fully restored.

DATED: August 6, 2004


H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings