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

In the Matter of the Petition for the Reinstatement of the Revoked Certificate of: JEFFREY RUTGARD Physician's and Surgeon's Certificate No. G38603 Petitioner.	Case No. 20-2005-166127 OAH No. L2005090433

DECISION AFTER NONADOPTION

James Ahler, Administrative Law Judge, Office of Administrative Hearings, heard this matter on February 21, 2006, in San Diego, California.

Jeffrey Rutgard represented himself and was present throughout the proceeding.

Mary Agnes Matyszewski, Deputy Attorney General, represented the Office of the Attorney General, State of California, under Government Code section 11522.

Sworn testimony and documentary evidence was received, closing arguments were given, the recommendation from the Office of the Attorney General was considered, and the matter submitted on February 21, 2006.

The proposed decision of the administrative law judge was submitted to the Division of Medical Quality, Medical Board of California (hereafter "division") on March 21, 2006. After due consideration thereof, the division declined to adopt the proposed decision and thereafter on May 19, 2006, issued a Notice of Nonadoption of Proposed Decision and subsequently on June 13, 2006, issued a letter fixing date for submission of written argument. On June 28, 2006, the division issued a Notice of Hearing for Oral Argument. Oral argument was heard on July 27, 2006. The time for filing written argument in this matter having expired, written argument having been filed by both parties and such written argument, together with the entire record, including the transcript of said hearing, having been read and considered, pursuant to Government Code Section 11517, Panel B of the division hereby makes the following decision and order:

The attached proposed decision of the administrative law judge dated March 21, 2006 is hereby adopted by the division as its decision in this matter.

This decision shall become effective at 5:00 p.m. on September 11, 2006.

IT IS SO ORDERED August 11, 2006.

Shelton Duruisseau, Ph.D.
Panel B
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 Petition for the Reinstatement of Revoked Certificate of:	)	OAH No: L2005090433
JEFFREY RUTGARD	)	Case No: 20-2005-166127
Physician's & Surgeon's Certificate No: G 38603	)	
Petitioner.	)	

NOTICE OF NON-ADOPTION
OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** The Medical Board of California, Division of Medical Quality, will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit, including in particular, argument directed to the question of whether the proposed order should be modified. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Kennedy Court Reporters, Inc., 920 W. 17th Street, Second Floor, Santa Ana, CA 92706-3576, telephone (714) 835-0366, fax (714) 835-0641.

To order a copy of the exhibits, please contact the Transcript Clerk at the Office of Administrative Hearings, 1350 Front Street, Room 6022, San Diego, CA 92101, telephone (619) 525-4475.

In addition to written argument, oral argument will be scheduled if any party files with the Division within 20 days from the date of this notice a written request for oral argument. If a timely request is filed, the Division will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Division. The mailing address of the Division is as follows:

Medical Board of California
Division of Medical Quality
Attention: Arlene Krysinski
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
Telephone: (916) 263-2451

Dated: May 19, 2006

Arlene Krysinski

Enforcement Legal Unit
Arlene Krysinski, Associate Analyst

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

In the Matter of the Petition for the Reinstatement of the Revoked Certificate of: JEFFREY RUTGARD, Physician's and Surgeon's Certificate No. G38603 Petitioner.	Case No. ~~D-4747~~ 20-2005-166127 OAH No. L2005090433

PROPOSED DECISION

James Ahler, Administrative Law Judge, Office of Administrative Hearings, heard this matter on February 21, 2006, in San Diego, California.

Jeffrey Rutgard represented himself and was present throughout the proceeding.

Mary Agnes Matyszewski, Deputy Attorney General, represented the Office of the Attorney General, State of California, under Government Code section 11522.

Sworn testimony and documentary evidence was received, closing arguments were given, the recommendation from the Office of the Attorney General was considered, and the matter submitted on February 21, 2006.

FACTUAL FINDINGS

Background and License History

1. Jeffrey Rutgard (petitioner or Rutgard) was born on December 18, 1951. He received a medical degree from the University of Illinois College of Medicine in 1977. He completed a residency in ophthalmology at the University of Iowa and engaged in post-graduate studies at the Jules Stein Eye Institute at UCLA. Rutgard was board-certified by the American Board of Ophthalmology.

Rutgard presented himself as a "cataract, glaucoma and laser specialist." The primary focus of Rutgard's practice was cataract and eyelid surgery. Rutgard, a highly trained surgeon, was esteemed by virtually all of his patients and his technical and surgical skills were highly regarded by most of his colleagues.

2. Rutgard established a very large, extremely lucrative surgical practice headquartered in San Diego County.

By 1988, Rutgard was performing about 600 cataract surgeries a year, with a goal of performing 1,200 surgeries a year.

In 1989, Rutgard opened the La Jolla Eye Surgery Center, an outpatient surgical center. Through La Jolla Eye Surgery Center, Rutgard controlled a patient's course of treatment without a hospitalization.

By 1991, the La Jolla Eye Surgery Center was scheduling between 50-80 appointments per day at the La Jolla clinic and between 70-100 appointments a day at the San Diego clinic.

3. The La Jolla Eye Surgery Center was highly organized. Rutgard was responsible for supervising all aspects of the clinic's operation. The clinic employed an office administrator, a community relations department, ophthalmologic technicians and scribes, a surgical counselor, registered and licensed vocational nurses, certified registered nurse anesthetists, drivers to provide patients with transportation, front-desk personnel and a billing department. Rutgard set quantifiable goals for employees, the purpose of which was to require employees to be more accountable for their time and to permit the scheduling and providing of more surgeries. More was deemed better, and patients were encouraged by the clinic's staff to undergo surgeries in a variety of ways.

As stated in the Board's Decision:

> "Though distasteful to some, there is nothing wrong with a physician marketing his services so long as the sales pitch stops at the office door. Respondent allowed and encouraged the pitch to continue in the examining room, selling eye surgery as if it were the latest in video equipment, being less than candid about the quality and benefits of the product and leaving it up to the patient/buyer to beware of any risks."

According to the Board's Decision:

> "Respondent consistently and intentionally failed to meet his responsibility to provide surgery patients with the information necessary for them to make a voluntary and informed decision to have surgery. When a patient specifically asked respondent to explain the cataract condition he generally did so, but normally it was the technician's duty to describe the condition before respondent saw the patient.

Respondent encouraged the technicians and scribes to tell patients he was well trained, and had much experience with cataract surgery and was a very good cataract surgeon. He wanted the technicians to prepare the patient to be comfortable with his skill and not surprised when he diagnosed cataracts . . . ."

With regard to eyelid surgeries, Rutgard instructed patients to close their eyes or to keep them open ~~them~~ halfway or look sleepy when they had their pictures taken. Rutgard instructed his staff to take photographs of the patients in those posed conditions or to take pictures of patients who were already sedated to provide justification for eyelid surgery.

Rutgard measured visual acuity with a Brightness Acuity Tester set at the highest setting and not at other more appropriate settings. He specifically advised technicians who administered the test to either use or record only the findings on the high setting and to administer the testing with less than best corrected vision in place to justify cataract surgery.

Rutgard prohibited technicians from noting in patient charts that a patient had no vision problems to make his Medicare billing easier. In March 1991, Rutgard told his surgical counselor it was her duty to circle at least two complaints for each patient when taking a history and to include in a patient's chart a complaint of decreased vision as well as other visual complaints to justify the need for surgery. Rutgard instructed his staff to write "PARDISC" on all patient charts (an acronym for "procedures, alternatives, risks of a procedure were discussed with a patient) even when such information was not given.

Rutgard had his billing clerks falsely date EKGs done in the surgery center on the day of surgery as if the EKGs had been done the day before at the clinic because an EKG done on the day of surgery was a global fee and would not be reimbursed by Medicare.

4. In 1992, federal agents and Board investigators executed duly issued search warrants at Rutgard's offices and home. Numerous records and documents were seized.

5. On May 15, 1992, an Interim Suspension Order was issued under Government Coe section 11529, which prohibited Rutgard from practicing medicine until further order.

6. On June 2, 1992, an Accusation was filed with the Board, seeking the suspension or revocation of Rutgard's certificate. It was amended several times. On March 18, 1994, a Third Amended Accusation was filed, charging Rutgard with gross negligence, repeated negligent acts and dishonesty, and knowingly making false statement of facts in medical documents, creating false medical records, employing unlicensed persons to engage in the practice of medicine, practicing while his license was suspended, and repeated acts of clearly excessive prescribing.

Administrative Law Judge Joyce A. Wharton presided over a 28-day administrative hearing. Rutgard was present and was represented for much of the hearing. Rutgard's attorney withdrew from representation when all but two days of the hearing were completed. Rutgard did not employ other counsel to represent him for the last two days of the hearing

and did not appear himself. On April 27, 1994, the record was closed and the matter was submitted.

On May 18, 1994, ALJ Wharton issued a Proposed Decision. She determined all causes of discipline alleged in the Third Amended Accusation were established by clear and convincing evidence including unprofessional conduct based upon gross negligence, repeated negligent acts, and dishonesty, as well as knowingly making false statement of facts in medical documents, creating false medical records, and employing unlicensed persons to engage in the practice of medicine. However, ALJ Wharton determined the charges related to practicing while his license was under suspension and repeated acts of clearly excessive prescribing were not established.

The Proposed Decision directed that Rutgard's certificate be revoked.

The Board adopted the Proposed Decision as its Decision in the matter, which became effective on June 24, 1994. Rutgard's certificate was revoked.

Rutgard's Conviction

7. On May 15, 1995, Rutgard was convicted by a jury in the United States District Court, Southern District of California, in Case No. 101990001472 of 28 counts of mail fraud, 80 counts of making false claims, and 22 counts of making false statements. Rutgard was sentenced to serve 135 months (11.25 years) in federal prison, to pay a $150,000 fine and to make restitution of approximately $16,000,000. Bail was denied pending appeal and Rutgard was immediately incarcerated.

On appeal, the United States Court of Appeals for the 9th Circuit affirmed Rutgard's conviction on Counts 1-3, 7-12, 14, 21 26, 38-41, 44, 47-56, 67-68, 71-90, 93, 96-97, 117-124, 127, 130, 149-158, 163-164, 167-175, 180, 182-190, 198-203, 209-210 and 212-215 and reversed his convictions on Counts 13, 19, 20, 42, 43, 69, 70, 91, 92, 94, 95, 115, 116, 125, 126, 128, 129, 159, 160, 165, 166, 216 and 217. It reversed the judgment of criminal forfeiture. The 9th Circuit vacated sentence and remanded the matter for resentencing.

Rutgard was ultimately ordered to pay a fine of $50,000, to make restitution of $113,000, and to serve a five-year term in prison. Rutgard served his sentence in correctional facilities in New Jersey and Texas.

Rutgard was released and came under the supervision of the equivalent of a federal parole officer, Javier Suarez. On July 21, 2002, Rutgard completed his period of federal supervision.

The Petition

8. On May 2, 2005, Rutgard filed a petition for the reinstatement of his revoked certificate. He represented his license to practice medicine in Illinois was reinstated in July

2003 and his license to practice medicine in Pennsylvania was reinstated in August 2004. Rutgard indicated his licenses to practice medicine in Iowa, Arizona and Hawaii had been revoked based on the Board's decision.

Rutgard represented he was involved with "Medical Missions" and he was employed by Mount Soledad Presbyterian Church from February 1999 through August 2001.

In his narrative statement, Rutgard stated he was genuinely remorseful and emerged from a painful and difficult prison experience inspired and determined to find a way to reestablish his life as a dedicated physician and human being. To this end, Rutgard said he worked at the Mount Soledad Presbyterian Church caring for the homeless and needy, and in the past six years he participated in numerous international medical missions in which patients needing eye care were treated in Africa, South America, Turkey, Jamaica, Burma, Vietnam, Columbia, Mexico, Tonga, Fiji and Ecuador.

Rutgard stated he was responsible for all problems and shortcomings associated with his revoked practice, even those he did not know about, because he was the "captain of the ship." Rutgard did *not* acknowledge specific acts of misconduct. Rutgard did *not* express any concern for any patient who underwent unnecessary surgery. Rutgard stated his past was behind him, he had engaged in meaningful psychotherapy, and he was rehabilitated. Rutgard expressed an interest in working in a smaller practice with one or more other physicians.

The petition was accompanied by letters of support authored by John Hassler, M.D., a Clinical Professor in Psychiatry at the UCSD School of Medicine; Bruce Barshop, M.D., a Professor at the UCSD School of Medicine, Department of Pediatrics; Robert B. Miller, M.D., a physician with Medical Vision Technology in Yolo County; John Harvey, Chairman, Medical Ministry International; Pamela Magenheimer, R.N., Director of Surgical Programs, Surgical Eye Expeditions (SEE) International; Paul E. Tornambe, M.D., a physician with offices in Poway; and, Mark Slomka, Pastor, Mount Soledad Presbyterian Church.

Numerous certificates of completion concerning Rutgard's continuing professional education were attached to the petition.

Petitioner's Testimony and Other Evidence

9. Petitioner read from a prepared statement. Petitioner said the "toughest part of apologizing is realizing and admitting that you were wrong." Petitioner said he was "embarrassed, saddened and ashamed by my past behavior" and took "full responsibility." He said he let "ambition and false pride lead me to poor judgment and greed" and his priorities were "selfish" and he was sorry for his "dishonest, negligent and unethical actions." Petitioner did not describe any wrongful conduct in a specific fashion.

Petitioner said he spent time in humble prayer and self-reflection, and on a life devoted to others while he was in prison. He helped fellow inmates and correctional staff members in the penal facilities in which he was incarcerated. After his release, petitioner

worked for his church, serving the needy, after which he volunteered his time and expertise in international medical missions. By the end of 2006, petitioner said he will have participated in more than three dozen separate international volunteer medical missions and in nearly two dozen community service and non-medical volunteer efforts. Petitioner testified his life "was devoted to others."

Petitioner said he would like to return to the practice of medicine. He would like to better provide for his wife and five children. He would like to leave his family with a legacy of honesty and integrity. Petitioner said he wanted to practice compassionate, ethical and skillful medicine.

Petitioner did not acknowledge specific instances of wrongdoing, instead merely stating there were false billings and some unnecessary surgery. Petitioner denied having any knowledge of employees creating false test results or false chart notes, although he conceded he did not oversee his operation as thoroughly as he should have. He conceded his "ambition was way out of control."

Petitioner saw Dr. Hassler for "depression" and "stress" after criminal charges were filed. He saw Dr. Hassler after his license was suspended and before going to prison. During this period of time, petitioner received $100,000 per month in disability insurance payments. These disability payments stopped in May 1995.

10. Dr. Tornambe testified. He has known petitioner for 25 years, both as a colleague and a friend. He believed petitioner was a highly skilled surgeon, although he acknowledged petitioner engaged in some medical practices that "raised some eyebrows." Dr. Tornambe actually spoke with petitioner about possible improper practices before the administrative and criminal actions were filed.

Dr. Tornambe attended petitioner's criminal trial and reviewed the cases allegedly involving fraudulent billing and unnecessary surgery. Dr. Tornambe noted some of the prosecution witnesses were petitioner's competitors. Although petitioner's appeal in the criminal action was, in part, successful, Dr. Tornambe believed petitioner was "punished beyond the norm."

Dr. Tornambe supported the granting of the petition, testifying petitioner was a "new person, a better human being." He spoke about petitioner's work with the Mount Soledad Presbyterian Church and his many international medical missions. Dr. Tornambe believed petitioner would approach a new opportunity to practice medicine with the same compassion, dedication and zeal as he exhibited in his medical missions.

11. Dr. Barshop was petitioner's neighbor in La Jolla before petitioner was arrested. He was shocked to learn of petitioner's arrest. According to Dr. Barshop, petitioner is a now changed person and has become rehabilitated. He believed petitioner was more thoughtful, conscientious and devout that ever before. Dr. Barshop had not read the Board's action report.

Dr. Barshop supported the granting of the petition.

12. Dr. Hassler has been a psychiatrist for 33 years. He saw petitioner for several years before petitioner's incarceration, just after petitioner's certificate was suspended, and then again following his release from prison. Dr. Hassler testified petitioner was clearly swept up in the desire to make lots of money in a large practice and he lost control over his goals. Petitioner was in "denial and confusion" at the time. While seeing petitioner about 20 times between 1992 and 1995, Dr. Hassler diagnosed an adult adjustment disorder, with depression, for which he prescribed medication.

Since February 2002, Dr. Hassler has seen petitioner 11 times. In those meetings, petitioner has expressed great remorse and did not sidestep his responsibility. Dr. Hassler believed petitioner had no significant internal conflicts and could practice safely.

Dr. Hassler supported the granting of the petition.

13. Duane Harding, an attorney, has known petitioner since 1993. Both petitioner and Harding attend the Mount Soledad Presbyterian Church. Harding visited petitioner in prison and observed a remarkable transformation. Petitioner was initially broken and angry, focusing on the wrongs he believed were visited upon him, but since then petitioner's views have changed and he has become more devoted to caring for others.

Harding supported the granting of the petition.

14. If called to testify, Dr. Harvey would have testified that petitioner worked under Dr. Harvey's supervision in many international medical missions and demonstrated compassion, good judgment, and thorough clinical skills in the most challenging situations. Dr. Harvey believed petitioner was an excellent ophthalmologist and recommended the petition be granted.

15. If called to testify, Nurse Magenheimer would have testified that petitioner has been affiliated with SEE International since 1999, providing volunteer medical services to the needy. Petitioner was a skilled practitioner who enjoyed an excellent reputation.

16. Dr. Miller, a board-certified ophthalmologist who is on the clinical staff at the UC Davis School of Medicine, testified he met petitioner three years ago on a medical mission in Mexico and since then petitioner has established himself as "a legend." He has observed petitioner perform thousands of examinations and hundreds of surgeries on the most difficult cases in very demanding conditions. Most recently, petitioner employed his formidable organizational skills to help the program run far more efficiently.

Dr. Miller supported the granting of the petition.

17. Pastor Slomka has known petitioner since 1992, when he met petitioner on a family retreat. According to Pastor Slomka, petitioner is "fundamentally a new person." He thought petitioner got a "raw deal" in the criminal proceeding and was treated much worse than other professionals charged with fraud. As a result of his misfortune, petitioner's "shell was broken and a new man has emerged." Pastor Slomka believed petitioner would conduct himself in a highly ethical and upright manner if his petition was granted.

The Attorney General's Recommendation

18. The Attorney General's Office noted petitioner engaged in a sophisticated, widespread, prolonged pattern of misconduct including fraud and unnecessary surgery. While petitioner had engaged in much charitable work since his release from prison and had provided considerable volunteer service, he had not fully acknowledged his wrongdoing and had not accepted full responsibility for his misconduct and, in the absence of taking ownership for his misconduct, he had not rehabilitated himself.

The Attorney General's Office believed it was too early to grant reinstatement.

Evaluation

19. Rutgard was a highly educated, highly skilled, highly trained ophthalmologist who established a surgical practice of staggering proportions in the late 1980s and early 1990s. To build that practice, Rutgard falsified patient histories, misrepresented test results, recommended and performed unnecessary surgeries, and falsely billed governmental entities for the professional services he allegedly provided. Rutgard involved many others in his dangerous, unprincipled scheme. Rutgard did not pay attention to the counsel he was given by trusted colleagues. He was overtaken by ambition and greed.

Rutgard lost his medical certificate in an administrative proceeding for which he had so little regard that he did not even show up for the last two days of the contested hearing. Rutgard lost his freedom when he contested the factual basis of the federal government's claim, arguing he had not engaged in any wrongdoing.

Rutgard did not seek counseling or psychotherapy while he was actively engaged in this misconduct. Apparently his conscience did not bother him until his medical practice was suspended and he was charged with numerous crimes, when he sought treatment for stress and depression. Rutgard began treatment with Dr. Hassler, a psychiatrist, who diagnosed an adult adjustment disorder, with depression, for which he prescribed medication.

Rutgard spent five years in federal prison and about two years on supervision. While he was in prison, Rutgard had time to reflect on what he did. He was of service to others in prison. Rutgard was released from prison and placed on supervision. He was released from supervision in late July 2002. Rutgard's rehabilitation is best measured from that date.

Since February 2002, Rutgard has seen Dr. Hassler 11 times, about two or three times a year. Psychotherapy has not been strongly pursued. If psychological testing was performed, the results were not provided. Dr. Hassler did not provide a narrative report discussing how Rutgard has overcome those character defects that resulted in the fraudulent operation of the La Jolla Eye Surgery Center and his criminal conviction.

Rutgard's witnesses all spoke about how Rutgard has changed. Many were quite sympathetic to Rutgard's situation, believing Rutgard was the victim of zealous prosecution.

While that may be the case, Rutgard still has not admitted the full nature and extent of his personal wrongdoing, instead couching his contrition in such general terms as "ambition" and "greed" and "remorse." The undisputed facts are that Rutgard was the prime mover in a medical scam in which operative procedures were performed upon persons who did not need surgery for no reason other than Rutgard's desire for personal wealth. He corrupted others.

What Rutgard has really done since July 2002 is to donate his considerable surgical skills and organizational talents to helping needy patients abroad in areas where there is little oversight and virtually no regulation. In the two states where he has been reinstated – Illinois and Pennsylvania - where his actual performance could be more readily measured, he has done nothing.

If Rutgard wants to be reinstated to practice in California, he must fully admit all of his personal wrongdoing, he must embark upon a meaningful course of psychotherapy, and he must demonstrate his ability to return to the medical practice in some kind of setting other than a third-world country where his services are volunteered to organizations in great need of his skills.

20. Under all the circumstances, it would not be in the public interest to reinstate Rutgard's medical certificate at this time, even though Rutgard is apparently in the process of rehabilitating himself.

LEGAL CONCLUSONS

Statutory Authority

1. Business and Professions Code section 2307 provides in part:

"(a) A person . . . whose certificate has been revoked . . . may petition . . . for reinstatement . . .

. . .

(c) The petition shall state any facts as may be required by the division. The petition shall be accompanied by at least two verified recommendations from physicians and

surgeons licensed by the board who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

(d) . . . After a hearing on the petition, the administrative law judge shall provide a proposed decision . . . which shall be acted upon in accordance with Section 2335.

(e) . . . the administrative law judge hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the certificate was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability . . . ."

Regulatory Authority

2. California Code of Regulations, title 16, section 1360.2 provides in part:

"When considering a petition for reinstatement of a license, certificate or permit holder pursuant to the provisions of Section 11522 of the Government Code, the division or panel shall evaluate evidence of rehabilitation submitted by the petitioner considering the following criteria:

(a) The nature and severity of the act(s) or crime(s) under consideration as grounds for denial.

(b) Evidence of any act(s) or crime(s) committed subsequent to the act(s) or crime(s) under consideration as grounds for denial which also could be considered as grounds for denial under Section 480.

(c) The time that has elapsed since commission of the act(s) or crime(s) referred to in subsections (a) or (b).

(d) In the case of a suspension or revocation based upon the conviction of a crime, the criteria set forth in Section 1360.1, subsections (b), (d) and (e).

(e) Evidence, if any, of rehabilitation submitted by the applicant."

The Burden and Standard of Proof

3. In a proceeding for the restoration of a revoked license, the burden at all times rests on the petitioner to prove that he has rehabilitated himself and that he is entitled to have his license restored, and not on the board to prove to the contrary. *Housman v. Board of Medical Examiners* (1948) 84 Cal.App.2d 308, 315; *Flanzer v. Board of Dental Examiners* (1990) 220 Cal.App.3d 1392, 1398.

4. A person seeking reinstatement must adduce stronger proof of his present honesty and integrity than one seeking admission the first time. He must show by the most clear and convincing evidence that efforts made towards rehabilitation have been successful. *In re Menna* (1995) 11 Cal.4th 975, 986.

Relevant Factors in Determining Rehabilitation

5. Rehabilitation is a "state of mind." The law looks with favor upon rewarding with the opportunity to serve, one who has achieved "reformation and regeneration." *Hightower v. State Bar* (1983) 34 Cal.3d 150, 157.

6. Fully acknowledging the wrongfulness of past actions is an essential step towards rehabilitation. *Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933, 940.

7. Mere remorse does not demonstrate rehabilitation. A truer indication of rehabilitation is presented when an application for readmission to a professional practice can demonstrate by sustained conduct over an extended period of time that he or she is once again fit to practice. *In re Menna* (1995) 11 Cal.4th 975, 991.

8. Cases authorizing reinstatement to a professional practice on the basis of rehabilitation commonly involve a substantial period of exemplary conduct following the applicant's misdeeds. The more serious the misconduct and the bad character evidence, the stronger the applicant's showing of rehabilitation must be. In determining whether to grant an application, the commonsense notion is rehabilitation cannot be determined separate and apart from the offenses from which one claims to be rehabilitated. See, *In re Gossage* (2000) 23 Cal.4th 1080, 1098.

9. Since persons under the direct supervision of correctional authorities are required to behave in exemplary fashion, little weight is generally placed on the fact that a bar applicant did not commit additional crimes or continue addictive behavior while in prison or while on probation or parole. Similarly, good conduct generally is expected from someone who has applied for admission and whose character is under scrutiny. Thus, the relevant time frame for determination is from the date on which parole was completed and the date on which reinstatement was sought. See, *In re Gossage* (2000) 23 Cal.4th 1080, 1099.

10. Cause was not established under Business and Professions Code 2307 to grant the petition for reinstatement.

This conclusion is based on Factual Findings 1-20 and Legal Conclusions 1-9.

ORDER

The petition for reinstatement of Physician's and Surgeon's Certificate No. G38603 filed by Jeffrey Rutgard is denied.

DATED: 3/21/06

JAMES AHLER
Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the Accusation Against:	No. D-4747
JEFFREY JAY RUTGARD, M.D. 7630 Fay Avenue La Jolla, CA 92037	OAH No. L-57222
Physician's and Surgeon's Certificate No. G38603	
Respondent.	

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the MEDICAL BOARD OF CALIFORNIA, DIVISION OF MEDICAL QUALITY as its Decision in the above-entitled matter.

This Decision shall become effective on June 24, 1994.

IT IS SO ORDERED May 25, 1994.

Karen McElliott

KAREN MC ELLIOTT, President
Division of Medical Quality

OAH 15 (Rev. 7/90)

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

In the Matter of the Accusation Against:	)	No. D-4747
JEFFREY JAY RUTGARD, M.D. 7630 Fay Avenue La Jolla, CA 92037	)	OAH No. L-57222
Physician's and Surgeon's Certificate No. G38603	)	
Respondent.	)	

PROPOSED DECISION

On July 28, 29, 30, August 3, 4, 6, 10, 11, 12, 13, 17, 18, 19, 20, 26, 27, 31, September 1, 2, 3, 8, 9, 10, 13, 14, 15, 1993, and March 1 and 4, 1994, in San Diego, California, Joyce A. Wharton, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter.

Sanford H. Feldman, Deputy Attorney General represented the complainant.

Richard K. Turner, Attorney at Law, represented Jeffrey Jay Rutgard, M.D., who was present at hearing through September 15, 1993. The hearing was set to re-convene October 25, 1993. Due to a severe broken leg suffered by Mr. Turner, that hearing date was vacated. On December 10, 1993, the parties were notified that hearing would re-convene February 1, 1994. On January 14, 1994, at Mr. Turner's request, that date was vacated and hearing was set to re-convene March 1, 1994. On January 14, 1994, the order setting the new date was served on the parties. On February 1, 1994, a telephone conference was held to hear argument on respondent's motion to stay the hearing. On February 1, 1994, the Administrative Law Judge issued an order which denied the motion, confirmed the hearing date, and set a telephone pre-hearing conference for February 11, 1994. Mr. Turner withdrew from representation of Dr. Rutgard on February 10, 1994, without presenting any cause for withdrawal. Dr. Rutgard was aware of but chose not to participate in the telephone pre-hearing conference on February 11, 1994. On February 11, 1994, Dr. Rutgard was served with notice confirming the March 1 hearing date. When the hearing reconvened on March 1, 1994, no appearance was made by or on behalf of Dr. Rutgard.

Evidence was received and complainant rested its case on March 1, 1994. On March 3, 1994, complainant organized and submitted previously marked exhibits; again, no appearance was made by or on behalf of Dr. Rutgard. With notice given to Dr. Rutgard, the record remained open until April 27, 1994, to allow him to appear by himself or by representative. He did not retain any other attorney to represent him and refused to appear in pro per to present evidence in his defense. Respondent's motions to continue and/or stay the hearing were denied for failure to show good cause. On April 27, 1994, the record was closed and the matter was submitted.

FINDINGS OF FACT

1. On May 15, 1992, an Interim Suspension Order was issued pursuant to Government Code section 11529. The order, which precludes respondent from practicing medicine, has remained in effect throughout this proceeding.

2. On June 2, 1992, Kenneth J. Wagstaff, acting in his official capacity as Executive Director, Medical Board of California (complainant), filed Accusation No. D-4747 against Jeffrey Jay Rutgard, M.D. (respondent). On June 12, 1992, respondent, by his attorney, filed a timely Notice of Defense. On July 9, 1993, Dixon Arnett, acting in his official capacity as Executive Director, Medical Board of California, filed an Amended Accusation. On March 18, 1994, complainant filed a Third Amended Accusation in which several charges were withdrawn and allegations were amended to conform to proof.

Complainant charges respondent with violation of the following sections of the Business and Professions Code: 725, 2234 subsections (a) through (e), 2261, 2262, 2264 and 2306.[1] This Proposed Decision addresses only those issues raised by the Third Amended Accusation.

3. On December 21, 1978, the Medical Board of California issued to respondent Physician and Surgeon's Certificate No. G38603. The certificate is paid and current with an expiration date of December 31, 1994. There is no history of prior discipline.

/
/
/
/
/
/

[1] The pertinent language of these sections is set forth at pages 2 through 4 of the Third Amended Accusation.

4. RESPONDENT'S MEDICAL PRACTICE

Respondent is 42 years old. His promotional brochure represents he received his medical training at University of Illinois Medical School, University of Iowa and the Jules Stein Eye Institute at UCLA. He is an ophthalmologist who presents himself as a "cataract, glaucoma and laser specialist". Since at least 1987, respondent has had offices in San Diego and La Jolla. The primary focus of his practice was surgery for cataract[2], eyelid problems such as blepharoptosis (ptosis)[3] and dermatochalasis[4], radial keratotomy[5] and certain laser procedures. By 1988, respondent was performing about 600 cataract surgeries per year and his goal was to increase that number to 1200 per year. In mid-1989, he opened the La Jolla Eye Surgery Center for outpatient surgical procedures, serving as the Director and only surgeon. The La Jolla office includes both clinical and surgical facilities and allows respondent to control the patient's entire course of treatment without having to use a hospital. By 1991, respondent's clinic offices were scheduling between 50-80 appointments per day in La Jolla and between 70-100 appointments in San Diego.

---

[2] "Cataract" refers to an opacity or loss of optical quality of the crystalline lens behind the cornea of the eye. This results in a decreased image on the retina which in turn reduces visual acuity and visual performance. Cataract may be present at birth but the condition generally develops with age. There are different types of cataract which may have variable effects on visual acuity. Cataract surgery generally involves removal of the lens from its capsule and replacement with a plastic intraocular lens (IOL).

[3] "Blepharoptosis" is a condition manifested by a lowering of the upper eyelid below normal anatomic position. The lid margin droops excessively below the top edge of the cornea. This can cause merely a cosmetic problem or can also cause a functional problem when droop is sufficient to reduce the patient's superior visual field. Several surgical techniques to shorten muscles which open the lid can be used to raise the eyelid to a normal position.

[4] "Dermatochalasis" is a condition of excess skin on the upper or lower lids. The skin itself may hang in front of a normal eyelid and interfere with vision. Blepharoplasty (plastic surgery of the eyelid) can repair the condition.

[5] Radial Keratotomy is a procedure in which a series of incisions is made in the cornea in a spokelike fashion in order to flatten the cornea and correct myopia.

Respondent's practice was well organized, with employees chosen by him to supervise the various components of the practice.

A. Office Administrator

In November, 1988, respondent hired G.B. as office administrator to manage the practice and handle personnel and organizational issues. The staff was advised operational issues were to be directed to G.B. and medical issues to respondent. Although G.B. recommended respondent be more removed from the administrative aspects of the practice, he remained involved in the day to day operations and either authorized or was aware of the practices followed by his employees.

B. Community Relations Department

The Community Relations (CR) Department promoted respondent, coordinated and performed free vision screenings at locations frequented by groups of seniors, and provided free transportation to patients. The target communities were South East San Diego, National City, Chula Vista and Spring Valley because these areas had many seniors and minorities but few ophthalmologists. For a typical screening the CR director and technicians went to the site and made a presentation about eye problems and the type of surgery respondent performed. The technicians then conducted visual examinations and scheduled patients for office appointments. The CR department brought in about 50 patients per month and by 1991 was responsible for about 30% of the practice.

C. Ophthalmologic Technicians and Scribes

Respondent employed several ophthalmologic technicians to examine patients, perform tests and make chart entries. Patients were seen first by the technician who took a history, checked ocular pressure, performed the visual acuity exam and refraction, examined with the autokeratometer and slit lamp, administered other tests such as the BAT and visual fields, and wrote the findings and other notes in the chart. Respondent then came into the exam room and performed his own glaucoma test and slit lamp examination. If he diagnosed a cataract, the technician took the patient to the surgical counselor.

Technicians also performed the "A-scans" which determined the power of the lens to be implanted in the eye, assisted in minor procedures and often acted as "scribes". Respondent required a scribe present whenever he was examined a patient in order to chart what he said about the patient's condition and any pertinent comments made by the patient.

The technicians and scribes were trained either by respondent or by other technicians who had been trained by respondent. Respondent was either aware of and authorized the practices followed by his technicians and scribes or, in the exercise of the slightest diligence should have been aware of their conduct.

D. Surgical Counselor

Patients diagnosed with cataracts were immediately taken to the surgical counselor. Her role was to explain the surgical procedure to the patient, obtain information for the history and physical form, schedule surgery, pre-op and post-op dates, answer patient questions and obtain the patient's signature on the certain documents, including surgery consent forms.

E. Surgery Center

Respondent employed registered nurses, licensed vocational nurses and certified registered nurse anesthetists (CRNAs) to staff the La Jolla surgery center. On Mondays respondent performed various eyelid and laser surgeries; on Tuesdays he performed cataract and other eye surgeries. The facility had two surgery rooms which were in constant use on surgery days. Three patients at a time were prepped in pre-op and the pace was hectic. Respondent went back and forth between surgery rooms, a patient always being ready for him to immediately begin the surgery. By early 1992, respondent was performing at least 20 eyelid and 25 laser surgeries on Mondays, and 25 to 30 cataract surgeries on Thursdays.

F. Front Desk and Billing Departments

All of respondents billings and receipts were processed by his office. Respondent was involved in determining all billing policies and practices. If a question arose about how to bill a procedure, respondent's word was final. Respondent used billing consultants to advise how to properly bill Medicare and to keep up with the frequently changing rules. However, respondent did not always follow the consultant's recommendation if it would result in a reduced fee.

/
/
/
/
/
/
/

5. SURGERY GOALS

In 1991, respondent decided technicians should be more responsible for finding pathology and having patients schedule surgery. At management meetings with his administrator and supervisors he discussed the idea of setting quantifiable goals for employees, the purpose being to account for everyone's time, to see more patients and perform more surgery. It was decided to set an office goal for the number of surgeries to be performed in 1992 and each employee would be responsible for referring a number of patients who would ultimately have surgery. Respondent allowed his supervisors to set surgery quotas for employees under their supervision and he indicated satisfaction with the numbers. As of January 1992, the quotas for respondent's four technicians totaled 700 cataract surgeries, 950 eyelid surgeries and 112 radial keratotomies. Each technician was assigned a surgery goal based on her experience and ability. It was the technicians' responsibility to examine, counsel and follow through with patients in a manner which would result in the patient having surgery. Technicians were also responsible for tracking surgery cancellations and convincing patients to reschedule. Each front office and front desk employee was given a quota of referring four surgical procedures per year to respondent. A scribe hired in late 1991 was told part of her job was to "sell" surgery. Even drivers who provided patient transportation were "responsible for the education of one person every two months which results in a surgical procedure". An employee's 1992 raise was contingent upon his or her reaching the assigned surgery referral goals.

The setting of employee goals, of itself, is not wrong if in fact it does not create a setting for abuse or compromise patient care. But by the very nature of the goals set by respondent and the intent behind the goals, more surgery to bring more money into the practice, a setting existed where patient interests were secondary to the financial interests of doctor and staff. Though distasteful to some, there is nothing wrong with a physician marketing his services so long as the sales pitch stops at the office door. Respondent allowed and encouraged the pitch to continue in the examining room, selling eye surgery as if it were the latest in video equipment, being less than candid about the quality and benefits of the product and leaving it up to the patient/buyer to beware of any risks.

Directing and encouraging technicians to generate surgery by encouraging patients to have surgery is an extreme departure from the standard of care. Cataract and ptosis surgery are elective procedures and there should be nothing done to coerce the patient; it is for patient and doctor to make the decision based on all properly determined facts. Patients view the technician as a figure of some authority and her advocation or suggestion of surgery could be construed as a recommendation.

Respondent's technicians were motivated to say generally positive things about surgery and did not present full information or an unbiased viewpoint. This can negate the informed consent process.

6. STANDARD OF CARE RE: CATARACT SURGERY

The standard of care in the ophthalmologic community requires the physician to determine if the patient has a cataract by taking a careful history and performing a complete eye examination. The history is obtained by asking the patient about his or her vision and determining whether the patient is having difficulty performing any normal daily activities. The eye examination includes testing of visual acuity[6], best refraction[7], intraocular pressures, pupil exam, slit lamp exam of structures in front of the eye, direct ophthalmoscopic exam looking into the eye and indirect exam looking into the retina. It is critical for the physician to obtain the patient's "best corrected vision" because the standard of practice refers to this as the basis for every other determination. The initial refraction can be done by the technician but best corrected vision should be confirmed by the physician's examination.

If the best corrected vision is worse than 20/40 and the patient complains of glare or reduced vision in bright light, then additional tests may be performed to evaluate glare and sensitivity contrast problems. "Glare" relates to reduction in vision in bright light situations. During the day, light scattering causes reduced contrast; at night, it causes rays or a starburst effect. All types of cataracts cause some degree of light scattering; however, there are other causes such as corneal scars or vitreous abnormalities and the physician must determine the cause by artful use of various examining instruments. This determination must be made by the physician, not by technicians.

Cataract development is expressed as a continuum spanning stages or degrees from "trace" through "4+". Although evaluation is somewhat subjective, there is agreement in the ophthalmologic community that "trace" signifies a very early lens change with virtually nothing but a minor clouding, 1+ means a little more clouding and/or hazing, 2+ is early to medium

---

[6] Visual acuity is generally tested by using the Snellen chart which contains a series of 10 high contrast letters to be read by the patient. This is normally done in a dark room and does not always relate to vision in other light situations. The test results in acuity values such as "20/20", etc.

[7] "Refraction" refers to the determination of refractive errors of the eye and their correction with optic lenses.

yellowing of the lens, 3+ is a distinct yellow, and 4+ is the ultimate brunescent dark lens. It is not unusual for ophthalmologists to differ within one grade in rating the same cataract; however, it is not possible within this standard of grading to confuse a trace or 1+ cataract with a 3+ condition.

Cataract surgery is currently one of the most successful operations performed but it is not without risk. Possible complications include cystoid macular edema resulting in worse vision after surgery, retinal detachment, corneal edema or decompensation, ophthalmitis and loss of vision. The physician should not expose the patient to these risks unless there will be a sufficient benefit in terms of improving functional vision.

The effect of cataract surgery on vision must be assessed and a determination made whether surgery is indicated. The physician must consider not only the degree of cataract and visual acuity but also the patient's overall functioning and any needs which demand better vision. The patient's own assessment of the effect of the cataract on daily life is crucial and, with rare exception, the physician should never recommend surgery to someone who is functioning well and happy with their vision. Evaluation of the patient's overall health is crucial because there are medical conditions where surgery would not be indicated. The physician must consider and advise the patient of alternatives to surgery. A new optic lens prescription may be sufficient or, for some people with daytime glare problems, sunglasses are a viable alternative to the risk of surgery. The patient's needs are the ultimate priority in making the decision. All of the other subjective and objective findings made by the physician serve to substantiate whether the patient's subjective complaints warrant surgery.

When a patient's vision can be improved through optical aids, a physician who fails to advise the patient of this alternative to surgery departs from the standard of care and is negligent. Findings below establish respondent routinely failed to advise patients of alternatives to cataract surgery.

A physician who recommends cataract surgery to a patient who does not need it or whose vision problem is caused by a condition other than cataract commits an extreme departure from the standard of care and is grossly negligent. Findings below establish respondent routinely recommended and/or performed cataract surgery on patients who did not need it or whose vision problem was caused by a condition other than cataract.

/
/
/
/
/
/

7. STANDARD OF CARE RE: PTOSIS

A ptosis condition exists when the upper eyelid margin hangs more than 2 millimeters below the upper edge of the cornea. The condition results from a problem with the muscles that raise the eyelid. A proper examination for ptosis includes evaluating the functional condition of the levator muscle in order to rule out neurogenic types of ptosis, measuring the amount of ptosis, checking corneal sensation and tear film, and assessing lid crease position to plan surgery for a symmetric result. "Mild" ptosis describes a lid droop of between 2 and 4 millimeters below the cornea edge; moderate is 5 millimeters and severe is greater than 6 millimeters. A photograph alone will not show the amount of visual impairment. It is necessary to perform a "visual field" test which evaluates the entire visual area of each eye separately. The confrontational visual field test is the type commonly used by ophthalmologists and, if done carefully, can provide an accurate assessment of the patient's visual field.

Medical indications for ptosis repair surgery are loss of superior visual field caused by the drooping lid, decompensating corneas, or cosmesis when the patient does not like the lid appearance. Risks of ptosis surgery include an asymmetric result, overcorrection, dry eyes, keratitis, corneal ulcer which may result in blindness, orbital hemorrhage and adverse reaction to local anesthetic. Because there are risks to this surgery, it should be done only when the ptosis condition causes a problem which the patient wants to have corrected. Ptosis repair surgery can be done by an external approach through the skin of the lid or by an internal approach through the conjunctiva by flipping the lid over. Both methods involve an incision and it is a departure from the standard of care to represent to a patient that the internal ptosis repair procedure does not.

Dermatochalasis (excess skin on upper or lower lids) may result in loss of superior vision where the eyelid skin hangs in front of the cornea. This condition can be repaired by a blepharoplasty, the removal of skin and fat pads. Medical indications for this surgery are loss of visual field and cosmesis.

A physician who recommends ptosis repair surgery to a patient who does not in fact have the condition or who has no problems caused by the condition commits an extreme departure from the standard of care and is grossly negligent. Findings below establish respondent allowed his technicians to "diagnose" a ptosis condition for any patient they thought had droopy lids. Diagnosis was made, surgery was recommended and performed without doing any of the tests required to determine if a true ptosis condition existed.

8. PHYSICIAN'S DUTY RE: INFORMED CONSENT

Respondent is required by law and by the standard of care in his profession to obtain the patient's informed consent before performing any surgical procedure. This obligation is not met by merely obtaining the patient's signature on a form; the consent process requires not the signing of a form but the communication and discussion which occurs before it is signed. It requires a meaningful communication with the patient about the medical condition, the patient's needs, the dangers involved in surgery and alternative treatments. The nature of the physician's duty and the reason for it are set forth in Cobbs v. Grant (1972) 8 Cal.3d 229 at 242-243:

> "Preliminarily we employ several postulates. The first is that patients are generally persons unlearned in the medical sciences and therefore, except in rare cases, courts may safely assume the knowledge of patient and physician are not in parity. The second is that a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment. The third is that the patient's consent to treatment, to be effective, must be an informed consent. And the fourth is that the patient, being unlearned in medical sciences, has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process, thus raising an obligation in the physician that transcends arms-length transactions.
>
> From the foregoing axiomatic ingredients emerges a necessity, and a resultant requirement, for divulgence by the physician to his patient of all information relevant to a meaningful decisional process. In many instances, to the physician, whose training and experience enable a self-satisfying evaluation, the particular treatment which should be undertaken may seem evident, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which he believes his interests lie. To enable the patient to chart his course knowledgeably, reasonable familiarity with the therapeutic alternatives and their hazards becomes essential.
>
> Therefore, we hold, as an integral part of the physician's overall obligation to the patient there is a duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each."

Before performing cataract surgery, ptosis repair, radial keratotomy, or any other type of surgical procedure, respondent is obligated to engage in a meaningful discussion with his patient about the true nature of the medical problem, alternative methods of treatment, including the option not to have surgery, the risks of any proposed surgery and the benefits to the patient with or without surgery.

The standard of care requires a truthful and unbiased presentation so the patient can truly make a voluntary and informed decision. Any attempt by respondent or his staff to influence the decision violates the precepts of informed consent. It is not inappropriate for respondent to designate a non-physician employee to provide the patient with some of the necessary information so long as the physician discusses those matters which require his particular knowledge and experience.

It is an extreme departure from the standard of care and, thus, gross negligence, for a physician to fail to advise a patient of the risks associated with cataract or ptosis repair surgery. It is an extreme departure from the standard of care to perform cataract or ptosis repair surgery without the informed consent of the patient. Findings below establish respondent routinely failed to provide meaningful or accurate information to patients about risks and alternatives to surgery and performed surgery without patients' "informed" consent.

9. FAILURE TO PROVIDE CONSENT INFORMATION

Respondent consistently and intentionally failed to meet his responsibility to provide surgery patients with information necessary for them to make a voluntary and informed decision to have surgery. When a patient specifically asked respondent to explain the cataract condition he generally did so, but normally it was the technician's duty to describe the condition before respondent saw the patient. Respondent encouraged the technicians and scribes to tell patients he was well trained, had much experience with cataract surgery and was a very good cataract surgeon. He wanted the technicians to prepare the patient to be comfortable with his skill and not surprised when he diagnosed cataracts. Respondent instructed the technicians not to discuss the risks of surgery with patients because he wanted the them to be as comfortable as possible and did not want to scare them.

Respondent himself did not take the time to discuss risks and alternative with each patient. He allowed the primary responsibility for providing information about risks and alternatives of surgery to fall on the surgical counselor who had no formal medical training and no real understanding of the concept of informed consent. She gave patients a three page form

document containing information about risks and alternatives but the patient was rarely given time to read it and ask questions. The counselor's goal was to obtain the patient signature on the third page, tell the patient it meant they were consenting to surgery, and to schedule a date. After the patient signed the consent, a full copy was given to them to take home and read. However, by that time most patients were influenced more by the enthusiastic and positive surgery recommendations made by the technicians and respondent than by the printed form. In February or March, 1992, respondent instructed the counselor she should no longer give patients the portion of the consent form containing information about risks and alternatives. He explained that some patients had cancelled surgery after reading about the risks; he felt patients should not be scared of surgery and the way to prevent this was to omit any mention of risks. Respondent advised the counselor that if a patient asked a direct question about risks she could answer but must not initiate the discussion.

Respondent and his technicians encouraged patients to have ptosis surgery. Respondent advised patients the internal repair procedure would take only ten minutes and involved only taking "a little tuck" and lifting the lid. He felt he did not have to tell the patient an incision would be made because the cut was not made on the outer skin but on the inside of the lid. He did not mention the anesthetic, any risks or that they would have to be in the surgical center for at least two hours. When patients arrived for surgery, the they were given surgery consent forms to sign at the reception desk without having time to read them or ask questions. This caused confusion and delay on very hectic surgery days. On several occasions in 1990 and 1991, staff members expressed to respondent their concern that many patients arriving for eyelid surgery on Mondays seemed unaware a surgical procedure was going to be performed. The staff suggested respondent provide a counselor for eyelid surgeries. Respondent refused, saying he did not want to scare patients or make them overly concerned about the procedure.

Respondent, as a routine policy and practice, failed to provide patients with information needed for an informed consent to surgery, provided information in a meaningless or ineffective manner, or intentionally withheld pertinent information from the patient. This conduct constitutes an extreme departure from the standard of care and is grossly negligent.

/
/
/
/
/
/
/

10. CREATION OF FALSE MEDICAL RECORDS FOR EYELID SURGERY

Medicare and some insurance companies will not pay for repair of a ptosis or dermatochalasis condition unless it causes a sufficient loss of the patient's visual field. To obtain payment from these sources, the physician often must provide documentation of condition and visual loss by submitting photographs and visual field test results. By 1991, respondent and his staff were routinely creating photographs and visual field test results which falsely represented the patient's condition. This was done in order to justify surgery and obtain payment.

A. Visual Field Tests

Visual field (VF) tests are administered to patients to determine if they suffer any loss of visual field. An automated VF test uses an instrument which flashes points of light in various quadrants of the visual field, the patient presses a button when he sees the light and a computer printout records the results, showing a diagram of the points missed by the patient. A confrontational visual field test is done manually with the examiner holding her hand outside the field of vision and slowly moving it inward until it can be seen by the patient. The examiner records the results on a chart by marking an "x" at the points at which the hand is first seen and then drawing a line connecting the points. By looking at the VF test results the examiner can determine the extent of any loss of superior visual field in a patient with drooping lids.

In 1991, the California Medical Review Institute (CMRI) began an intensified review of respondent's patient charts to verify the patient's condition and services rendered. For patients who had undergone ptosis repair surgery, CMRI required evidence of visual field obstruction in the form of an automated VF test printout or confrontational VF test drawing. In order to satisfy private insurers and CMRI that eyelid surgery was necessary, respondent needed a VF test in each chart which reflected a significant loss of superior vision.

Respondent decided to use automated visual field tests but soon found them to be too time consuming. The technicians and scribes were administering the tests and many patients were not doing poorly enough to get insurance coverage for the surgery. Respondent instructed B.N., supervisor of technicians and scribes, to encourage patients to do poorly on the test and to tell them, if they wanted insurance to pay for surgery, they should miss some of the lights. B.N. relayed these instructions to technicians and scribes under her supervision. Nevertheless, patients continued to get good test results. To solve this problem, technicians and scribes began to take automated VF tests

for patients, to copy the printouts which showed loss of superior vision, and to place these false results in the charts when a visual field was needed. At least one technician felt that creating a false visual field herself was no different than asking a patient to do it.

In early 1991, respondent decided to use the confrontational VF test and established a procedure for assuring the test result would be in the chart before surgery was performed. He instructed G.B., his office administrator, to review charts a few days before surgery and create a visual field test result based on the information in the clinic chart. Respondent told G.B. to look at notes and the eyelid drawing to determine the extent of ptosis. Finding 14C below establishes this chart information was not accurate. Respondent showed G.B. how to mark the VF test sheet to simulate different types and the necessary amount of vision impairment. G.B. followed respondent's instructions and fabricated the VF test results. He eventually made master copies which reflected the various types and levels of impairment. He would then choose what he thought was the appropriate VF for the patient, insert the patient's name and a date on the document, and place it in the chart. G.B. was not in any way qualified to evaluate a ptosis condition. Following respondent's instructions, G.B. created and placed false visual field test results in the patient charts marked Exhibits 45, 46, 47, 48, 49, 50, 51, 53, 54, 55, 56, 57, 58, 59, 60 and 61. On occasion respondent created false confrontational VF test results to place in the charts. In addition to the above exhibits, false visual field test results were placed in the charts marked Exhibits 7, 8, 20, 30 and 43. Respondent's conduct in the creation and use of these false medical records constitutes an extreme departure from the standard of care, dishonesty and corruption in the practice of medicine and the creation of false medical records for a fraudulent purpose.

B. Photographs

Photographs of patients scheduled for eyelid surgery were generally taken in pre-op while the patient was being prepped for surgery. The photos were taken by the CRNA or by one of the nurses. On occasion, respondent took the photos or observed the manner in which his employees took them. The patients were instructed to close their eyes completely and either open them halfway, or just take a peek, or look sleepy. For those patients scheduled for surgery to correct a drooping lower lid, the CRNA often pulled the lid down just before taking the picture. Respondent reviewed the photos before surgery and sometimes wanted another one taken to show more drooping of the lids. The CRNA routinely took photos of patients who had already been sedated. The great majority of the ptosis photographs did not represent the patient's normal appearance or actual ptosis condition.

The purpose of the photograph is to reflect the patient's natural state and document the patient has a problem needing correction. It is a departure from the standard of care to take a ptosis photo after the patient has been sedated because the patient will tend to have sleepy eyes which do not reflect their natural state. It is a departure from the standard of care to tell patients to close their eyes and "take a little peek", or to close their eyes more or to squint, because it falsely represents the true medical condition. Respondent's conduct in creating and using inaccurate photographs to document the need for surgery constitutes a departure from the standard of care, dishonesty and corruption in the practice of medicine, and the creation of false medical records for a fraudulent purpose.

11. BRIGHTNESS ACUITY TESTER

The Brightness Acuity Tester (BAT) is a glare testing device which simulates three daytime light levels and translates the vision measured by the clinician in the examining room to approximate what the patient's functional vision would be in those varying light levels. It is a tool to help the ophthalmologist determine if the patient's vision problem is consistent with various types of cataract or other eye conditions.

The BAT instrument has light settings of low, medium and high. The high setting simulates bright overhead sunlight in a highly reflective situation such as white sand, white concrete, snow, or flying over the top of clouds. It represents the type of functional situation experienced by a lifeguard, pilot or skier. The medium setting simulates any less reflective condition such as a sunny day with surroundings of foliage or a dark ground surface. The low setting simulates a typical indoor situation with light coming from windows or lights. The BAT simulates only daytime conditions and does not test for night glare.

The BAT instrument is held by the patient in front of one eye at a time while the other eye is covered. Looking through the BAT, the patient reads to her best visual level on the Snellen chart. Proper administration of the BAT requires testing with the patient's best corrected vision in place. If something less is used, the BAT score will be inaccurate and make the patient's functional vision seem worse than it really is. The patient must first hold the BAT instrument in place in front of the eye and read the 20/20 line on the Snellen chart with the BAT light off. The light is then turned to low setting, allowing the patient 10 to 15 seconds to adjust to the light before reading to the smallest legible line. The same procedure is then followed for the medium and high settings and the patient must be allowed time for the eyes to adjust to each new light level. If only one setting is to be used in giving the BAT test it should be the medium light.

Acuity tested at the high BAT setting can indicate the patient's visual disability under extreme situations of bright light but it is rare a person in the cataract age group would experience this light level on any regular basis. This setting alone is never sufficient to make the decision whether to recommend or perform cataract surgery. The physician must also factor in the patient's common activities, actual vision problems, the other examination results, and the functional vision as shown by the medium, and perhaps the low setting. In general, if the medium BAT visual acuity is better than 20/50 the patient does not need cataract surgery because there is no normal light situation in which she will not be able to function.

An ophthalmologist who performs a glare test by using only the high BAT setting or who predicates cataract surgery on the patient's visual acuity as measured only by the high BAT setting commits an extreme departure from the standard of care and is grossly negligent.

12. IMPROPER USE OF BAT

It was respondent's practice to use the results of BAT testing on the high setting to support his recommendation for and performance of cataract surgery. Respondent instructed the technicians who administered the BAT test to either use or record only the high setting because he believed it represented the light condition in southern California. Respondent allowed his technicians to administer the BAT test with less than best corrected vision in place. Respondent used BAT results to justify cataract surgery even though the tests were improperly administered and did not provide accurate information upon which a surgery decision should be made. Respondent represented to patients that their visual acuity was below a functional level based on his BAT test results. This conduct of respondent constitutes gross negligence.

13. USE OF UNLICENSED EMPLOYEES TO MAKE DIAGNOSES AND RECOMMEND TREATMENT

The terms "diagnose" and "diagnosis" refer to any undertaking, gratuitous or not, to determine if a person is suffering from a physical disorder and the representing to such person any conclusion about the physical condition (Business and Professions Code section 2038). The practice of medicine includes the making of diagnoses and a person who examines a patient and relays to that patient a specific diagnosis must be duly licensed (Business and Professions Code sections 2051, 2052).

/

/

It is appropriate for ophthalmologic technicians to check visual acuity and test ocular pressure but they are not qualified to make diagnoses of eye conditions such as cataracts or ptosis. By 1991, the supervisor of the CR department became more aggressive in the screenings. She and her technicians, none of whom were licensed to practice medicine, would tell patients at screenings they had cataracts and recommended surgery by respondent. Respondent was aware his CR department director and technicians were diagnosing cataracts and recommending surgery before patients had been seen by a physician, yet he did nothing to stop this practice. The CR director was advised by the office administrator to stop this practice but she refused to do so. When the administrator suggested respondent terminate her employment, he refused to do so because he needed her to maintain the volume of the practice.

Respondent told ophthalmologic technicians he could spend less time with each patient if they were aware of their eye problems before he examined them. He instructed his technicians how to recognize a cataract and to distinguish one type from another. He instructed technicians, if they thought the patient had a cataract, to tell the patient and discuss it. In 1990, respondent instructed the technicians, if they thought the patient had droopy lids, to tell them the condition limited their vision and respondent could perform a simple procedure to correct it. Technicians examined cataract patients on their post-op visit. By late 1991, it was respondent's practice to have the technician tell most post-op patients their lids were drooping a bit and respondent would take care of it for them. Scribes were instructed, when a technician determined a patient had ptosis, to draw a diagram of the eyes showing the lid obstructing the pupil. Neither technicians nor scribes were competent to evaluate the existence or degree of ptosis.

By the end of 1991, respondent's technicians were routinely examining patients, giving diagnoses of cataracts and/or ptosis, and recommending corrective surgery by respondent. This constitutes the unlicensed practice of medicine and was done with respondent's knowledge, consent and encouragement in order to increase the number of surgeries performed and thereby increase the income to his medical practice.

14. FALSE OR INACCURATE MEDICAL RECORDS

The physician is responsible for the accuracy of findings and information placed in patient charts. This does not mean he is subject to discipline for honest or inadvertent mistakes. However, when the physician allows employees to make entries about the patient's condition he must take whatever steps are necessary to assure the entries are correct. With regard to the information placed in many of his patient's charts,

respondent made no effort to insure accuracy, he intentionally created false documents (see Finding 10), he knowingly permitted inaccurate entries (see Findings 11 and 12), and he ignored false information he knew or should have known was being placed in the chart. He did this on a routine, consistent and continuing basis as part of his practice and the result was financial benefit to himself and potential risk to his patients. Due to respondent's creation of false and inaccurate medical records many patient charts cannot be relied on to relate the true condition of the patient's eyes.

A. Patient Vision Complaints

Respondent instructed technicians they should not note in the chart that patients had no vision problems because Medicare would not pay for an exam without a statement of complaints. Each chart contained a form titled "PA WORKSHEET/INFORMED CONSENT" used for cataract surgery patients. Respondent circled the patient complaints listed under the medical necessity section and filled in the physician note section setting forth the reason for surgery. In March, 1992, he became too busy to do this and instructed his surgical counselor it was her duty to circle at least two complaints for each patient and to fill in the physician note section with a standard statement about the patient's decreased vision and complaints which indicated the need for surgery. The counselor complied and did this regardless of whether complaints circled or physician note was accurate for the patient.

B. "PARDISC"

Respondent instructed technicians and scribes to write "PARDISC" in the chart on every patient visit. This is intended to mean that procedures, alternatives and risks of a procedure were discussed with the patient. However, it was the policy and practice in respondent's office not to discuss the risks and alternatives of surgery unless the patient specifically asked. It was respondent's practice to have PARDISC entered in each patient chart even if there had been no such discussion with the patient. Scribes were instructed to write PARDISC upon entering the exam room so they would not forget. Technicians were instructed to write "no guarantees, pt's choice" in the chart for each patient scheduling surgery. This was done even if such matters were not discussed. Respondent knew of and authorized these false entries in charts. This practice constitutes a departure from the standard of care.

C. Entries Re: Ptosis

Technicians initiated discussions with patients about ptosis and made the initial determination whether a patient had a ptosis condition merely by deciding the patient had droopy lids.

Technicians and scribes were instructed to document the "ptosis" condition by drawing a picture in the chart. They did not intend the drawing to accurately reflect the patient's condition. They uniformly drew the picture showing eyelids covering part of the pupil and made entries such as "weak levator". This was done even though no examination or test was performed to determine the actual medical state of the patient's lids. Respondent knew the chart drawings and entries did not accurately reflect the patient's condition, yet he instructed employees to use these entries in creating the false visual field test results. (see Finding 9A).

D. CMRI Review Charts

In August, 1991, CMRI requested the charts of 24 patients who had undergone surgery in July, 1991. Respondent instructed his office administrator and supervising nurse on how to make the charts complete before being submitted to CMRI. If the surgery charts were missing hemoglobin test numbers, the proper operative report, signatures, or other vital information, respondent instructed his staff to fill in the missing information. This information was filled in even though it may not have reflected the patient's status at the time of surgery. Respondent instructed his office administrator to review each chart and make sure any visual field test appeared unique. This was necessary because of respondent's practice of using duplicated false visual fields for the charts. In accordance with respondent's instructions the administrator removed and destroyed the existing visual field, created new and unique false confrontational visual fields and placed them in the charts which have been marked Exhibits 7b, 8a, 30a and 43b. These charts were then sent to CMRI for review.

15. NON-STERILE SURGICAL PROCEDURES

Ptosis repair surgery is and has always been a sterile procedure. The physician is required to use aseptic technique, making every effort to sterilize the field of surgery and maintain sterility by using sterile gloves and instruments. Sterile gloves must be used because the procedure results in a wound and access to the bloodstream.

For eyelid surgeries performed on Mondays, respondent instructed his nurses to use a "clean" procedure where all items did not need to be sterile. At some point in late 1991 or early 1992, he began to use non-sterile examination gloves because they were less expensive. During ptosis surgery, patients were draped with a clean but not sterile towel. If the towel did not become soiled, it was used on more than one patient.

In performing surgical procedures on eyelids respondent used disposable, non-reusable sutures with needles attached. At some point in late 1991 or early 1992, respondent instructed his nurses that 40 silk retention suture could be re-sterilized in the autoclave and re-used. Respondent used the same suture on more than one patient until the needle became too dull. For ptosis surgery patients the sutures were placed in acetone but not in the autoclave before being re-used on another patient. Respondent felt suture was too expensive to waste. He instructed nurses if there was enough suture left for another patient, it be soaked in acetone and used again. Acetone is a solvent, not a sterilizing agent. Soaking sutures and needles in acetone after use is not an appropriate sterilization process and could harm the suture material.

Respondent intentionally established a policy and practice of performing eyelid surgery in a non-sterile manner. This was done solely for the purpose of saving money and with total disregard for patient welfare. This conduct constitutes an extreme departure from the standard of care and is grossly negligent.

16. DISHONEST BILLING PRACTICES

In 1990, respondent purchased an EKG machine and located it in the La Jolla surgery center. On surgery day, several patients had EKGs done just prior to surgery. Medicare did not pay for the EKGs done in the surgery center on the day of surgery because the cost was part of the global surgical facility fee. Medicare would pay if the EKG was done in the clinic offices. Respondent obtained this information from Medicare and discussed it with his billing clerk and his operating room supervisor. Respondent instructed his billing clerk to bill the EKGs as if they had been done in the clinic even though they were actually done in the surgery center on the day of surgery. The clerk followed respondents instructions.

YAG and ARGON laser procedures were done in the surgery center. Medicare did not pay for some YAG procedures done in the surgery center but would pay if done in the clinic. At some time after mid-1989, respondent instructed his billing clerk to bill the laser procedures in a way that would result in the highest payment instead of billing according to where the procedure had actually been performed. The billing clerk followed his instructions.

Medicare would not pay for a small surgical tray if the procedure was done in the surgery center. Respondent performed minor lesion procedures in the surgery center. At some time after mid-1989, he instructed his billing clerk to bill the procedure as if it had been done in the clinic so that Medicare would pay for the surgical tray.

The above conduct of respondent was knowing and intentional and resulted in the creation of medical documents which falsely represent facts for the purpose of obtaining payment from Medicare. Respondent's conduct was dishonest, corrupt and substantially related to the qualifications, functions and duties of a physician.

17. UNAUTHORIZED ASTIGMATIC CORRECTIONS

In about mid-1991, respondent began performing astigmatic corrections on patients at the time of cataract surgery if he felt it was necessary. The technicians who examined patients on their one day post-op visit began to hear unusual complaints of eye pain and irritation and, upon examination, saw the corneal incisions. The patients had not been informed prior to surgery that an astigmatic correction would be performed and had not been given opportunity to consent to or reject the surgery. The technicians did not tell the patients an additional procedure had been done because they did not want to alarm them. Respondent's performance of astigmatic corrections without giving the patient any advance notice and without informing them after surgery that the procedure had been done constitutes an extreme departure from the standard of care.

18. THE EMPLOYEE PAYOFF

D.P. was employed by respondent as a billing clerk from September, 1984 to April, 1989. D.P. was fired because she was constantly late for work and apparently unable to properly handle the work. She was angry about this and wanted revenge. Hoping to scare respondent into paying her money, she wrote a letter on May 10, 1989, in which she threatened to contact the fraud abuse hotline and accuse respondent of overcharging Medicare. D.P. had "suspicions" that certain billing practices followed by respondent were illegal. The evidence did not establish that any of the Medicare billing methods she was concerned about were in fact inappropriate. In response to her letter respondent met with D.P. to discuss her concerns. They talked about her accusations and respondent said he had done nothing wrong. Nevertheless, D.P. asked respondent what he would pay her to prevent her from calling the fraud abuse hotline. Respondent said he would pay her $10,000 and she accepted that amount. A few days later they met again; respondent gave D.P. a $10,000 check and reiterated her accusations were not correct. He had talked to an attorney and felt that settling D.P.'s claim was less expensive than the cost of litigation defense.

D.P. was a disgruntled employee, rightfully terminated, who set out in a blatantly corrupt manner to scare and blackmail her employer. It was she, not respondent, who suggested the

payment of money to settle the matter. While respondent's motives may appear somewhat questionable, complainant's evidence is not clear and convincing enough to establish the payment was made to prevent the disclosure of billing irregularities.

19. THE INTERIM SUSPENSION ORDER

The Interim Suspension Order suspended respondent's license to practice medicine. After it was issued another ophthalmologist, Dr. Hershman, saw respondent's patients at respondent's office. Respondent was present most of the time to introduce patients to Dr. Hershman and make them feel comfortable. Respondent spoke to the patients and asked how they were doing. On occasion he would mention a treatment for them to consider and tell them Dr. Hershman must examine them and tell them about it because he could not do so. Respondent was often present when Dr. Hershman examined the patient. At Dr. Hershman's request, respondent would look through the slit lamp and respond "I see what you are talking about" or "I agree". This conduct by itself does not constitute the practice of medicine. There is no evidence respondent attempted to influence Dr. Hershman to make any diagnosis or recommend any treatment. Complainant did not establish respondent violated any term or condition of the Interim Suspension Order.

20. Patient Minkin

Minkin was 66 years old on March 16, 1992, when he was examined by one of respondent's technicians at a CR department screening held at a senior center. He is retired and lives at a downtown hotel. At that time he wore glasses for reading but had no trouble with his vision. He did not drive a car and had never had a driver's license. The technician who examined Minkin did not ask if he was having any problem with his vision; she told him he had cataracts in both eyes and should have it taken care of by respondent. She advised him that if cataracts were left untreated he could lose his sight. Respondent knowingly employed an unlicensed person to examine the patient, diagnose a medical condition and recommend treatment.

Minkin was given an appointment and was examined by respondent on March 18, 1992. Respondent said he needed cataract surgery on both eyes. Minkin did not tell respondent or his staff he had any vision problem that was interfering with any of his activities. Minkin agreed to have the cataract surgery because respondent and his technician said he needed it. Respondent performed the surgery on the right eye on March 26 and on the left eye on April 9, 1992. After surgery Minkin's vision is the same and he still needs reading glasses.

Respondent's chart for Minkin contains entries stating the patient complained of blurry vision and problems in driving, seeing street and freeway signs, reading and watching TV, that he complained of vision interfering with his daily activities, and he had cataracts in both eyes consistent with his complaints. On March 18, 1992, a technician performed a BAT test on Minkin and entered into his chart the high BAT result. Respondent found Minkin's visual acuity to be 20/20 right eye and 20/25 left eye. Nevertheless, entries were placed in Minkin's chart stating his vision was borderline or below the DMV standard for driving, that his real life functional vision was 20/400, and this was consistent with his visual difficulties. Based on these entries, cataract removal was recommended.

The BAT test performed by respondent's technician was inaccurate and should not have been used as a reason for cataract surgery. The chart entries are false and were made by respondent's employees with his knowledge and consent and for the purpose of justifying cataract surgery. The recommendation of cataract surgery for Minkin constitutes negligence.

On March 18, 1992, respondent caused an entry to be made in Minkin's chart stating he had "levator weakness" in both eyes and making a diagnosis of ptosis; on April 1 and April 22, 1992, respondent made a chart entry for a diagnosis of ptosis. Although Minkin did not tell respondent or his staff his eyelids were interfering with vision, respondent told Minkin he needed ptosis repair surgery. Chart entries regarding the condition of Minkin's eyelids are false. Minkin had no levator weakness, no defects in his superior visual field and does not manifest any ptosis. There was no medical indication for ptosis surgery and respondent's recommendation of ptosis surgery constitutes negligence.

21. Patient Taylor

Taylor was 65 years old and unemployed in September, 1989, when respondent's screening team came to her senior apartments. At that time she was happy with her vision. She had reading glasses but rarely used them. She did not drive and was able to perform her daily activities without difficulty. She was taking medication that made her sensitive to bright lights. The technician who examined Taylor told her she had cataracts and glaucoma in both eyes and needed cataract surgery. An appointment was made for her to see respondent. Respondent knowingly employed an unlicensed person to examine the patient, diagnose a medical condition and recommend treatment.

Respondent examined Taylor on October 2 and November 6, 1989, and diagnosed cataracts. On February 7, 1990, respondent examined Taylor and caused the entry "dense anterior cataract" in

both eyes to be placed in her chart. He advised the patient he would continue to watch the cataract growth. Thereafter respondent examined Taylor on a regular basis. On January 15, 1992, respondent examined Taylor and found her best corrected vision to be 20/25 in both eyes and her BAT results to be 20/30 in both eyes. Respondent found cataracts in both eyes and graded the left eye cataract at 4+. He recommended she have surgery and sent her to the surgical counselor to schedule a date. On January 15, 1992, entries were placed in Taylor's chart stating, contrary to the visual acuity findings stated above, that her real life functional vision was 20/80 and she complained of decreased vision interfering with her daily activities. Taylor had not complained to respondent her eyesight was interfering with any of her activities. She agreed to have the surgery because she believed in and trusted respondent. At the suggestion of her primary care physician, Taylor sought a second opinion and ultimately decided not to have surgery.

Although Taylor does have cataracts in both eyes, the stage is only minimal or trace, a condition normal for her age. There was no medical indication for cataract surgery because Taylor had no vision complaints.

Respondent's conduct in recommending and attempting to schedule cataract surgery for Taylor constitutes gross negligence. The false entries placed in Taylor's chart by respondent and/or his employees were made with his knowledge and consent.

22. Patient Gerry

Gerry saw respondent on January 21, 1992, to inquire about cosmetic surgery to lift her right eyelid which she felt was heavier than her left. She had worn bifocals for 15 years and had no problem with her corrected vision. She was able to drive and perform all of her activities without problem. She was regularly examined by her own ophthalmologist because she had glaucoma. Although she only wanted to discuss her eyelid the technician performed a full preliminary examination of her eyes, including BAT. Gerry offered no complaints about her vision and no one asked her if she was having problems. Gerry's eyelids did not impair her vision in any way and no one asked her if they did.

When respondent entered the exam room he said, "This is wonderful, you will be so happy when I operate on your cataracts, you will see so much better." Gerry was surprised by this statement because her regular ophthalmologist had never indicated she had cataracts. Respondent told Gerry she would be able to read a menu without glasses after surgery and the procedure could be done in the office in 10 minutes. He did not describe the

surgery nor did he discuss any risks or alternatives to surgery. Respondent did not ask Gerry if she wanted to have cataract surgery; he acted as if the decision had been made and it was only a matter of when. He did not tell her she had a choice; he encouraged her to have surgery and gave her a list of satisfied patients to call. When Gerry asked respondent about correction of her right eyelid, he said it would be done after the cataract surgery. He told her the eyelid surgery was simple, he merely went under the lid and took one stitch. Respondent did not mention any risks of eyelid surgery. When Gerry asked respondent about the effects of surgery on her glaucoma condition, he told her that 50% of time cataract surgery will cure glaucoma. He advised Gerry that without surgery the cataracts would get worse and blindness would occur. Neither respondent nor his staff suggested a change in her glasses prescription to improve her vision; no one mentioned any risks of cataract or eyelid surgery. Contrary to respondent's diagnosis and recommendations for surgery, there was no medical indication for either cataract or ptosis surgery for this patient. Gerry had no vision problems and no ptosis condition. Respondent's conduct with Gerry constitutes gross negligence.

Respondent took photographs of Gerry to submit to her insurance company for the eyelid surgery. He told her to put her lids down as low as she could, saying "lower, more, more" before he took the picture. This conduct constitutes negligence.

Gerry was not given any type of visual field test on January 21, 1992. She never returned to respondent's office and was not given a visual field test on any other date. On January 22, 1994, Gerry called respondent's office and canceled the surgical procedures. Respondent caused false documentation of an automatic visual field test to be placed in Gerry's chart. The document falsely reflects that a VF test was given to Gerry on February 13, 1992, and falsely indicates a severe loss of superior vision in both eyes. Respondent's conduct constitutes gross negligence, dishonesty and the creation of false medical records.

Respondent caused false findings to be placed in Gerry's chart regarding conditions of cataract and ptosis and a false statement that risks and alternatives to surgery had been discussed. On January 31, 1992, respondent sent a letter to Gerry's insurance company falsely representing her condition as ptosis and recommending ptosis repair surgery on both eyes. Respondent knowingly made or allowed his employees to place false information in Gerry's medical record and to create a false medical record in order to obtain payment for unnecessary cataract and lid surgery.

23. Patient F.C.

F. C. was 72 years old and diabetic when he was examined by respondent's CR screening technicians on April 18, 1991. He was examined by respondent on April 25, 1991. Although respondent's chart does not indicate F.C. had any problems with his vision, he was diagnosed as having cataracts in both eyes and ptosis. Respondent recommended cataract surgery for both eyes and sent him to the surgical counselor who scheduled surgery for May 2, 1991. F.C. canceled the surgery date after obtaining a second opinion indicating surgery was not necessary. Nevertheless, respondent's staff called F.C. several times trying to convince him to have surgery.

There was no medical indication for recommending or performing cataract surgery on F.C. His eyes were examined by an ophthalmologist on January 15 and April 26, 1991. F.C. said he had no complaints about his vision or problems doing anything in daily life. His vision was correctable to 20/25 right eye and 20/20 left. He had no cataract in his right eye and only early mild changes in his left eye. Surgery would not have made any significant change in his vision. Respondent's conduct constitutes gross negligence because there were no visual complaints to warrant subjecting the patient to the risks of surgery.

24. Patient O'Donnell

On February 25, 1992, Medical Board Investigator Gerald O'Donnell, 56 years old and operating undercover as "Jerry Connell" went to respondent's office for an examination. An examination was performed by a technician who told O'Donnell he had cataracts in both eyes. She told him respondent specialized in cataract surgery and would tell him about it. Respondent knowingly employed an unlicensed person to examine the patient, diagnose a medical condition and recommend treatment.

Respondent examined O'Donnell for about ten minutes and told him he had cataracts in both eyes. Respondent recommended and encouraged O'Donnell to have surgery and sent him to the surgical counselor to schedule a date. The counselor did not explain the surgery or discuss any risks. She gave O'Donnell forms to sign and he followed her instructions. He signed where she indicated without reading the documents. No written information about risks or alternatives of surgery was given to him to take home. Respondent caused a document to be given to O'Donnell which falsely stated his vision was borderline or below the DMV standard. The false information was placed in the chart in order to justify the surgery and convince the patient to have surgery.

O'Donnell did not say he had problems focusing or with freeway signs, reading, headlights or TV. His eyelids do not bother him and no one told him he had ptosis or any weakness. Respondent caused false information to be placed in O'Donnell's chart about his vision complaints and the condition of his eyelids. Respondent diagnosed the patient as having ptosis and levator weakness. In fact, O'Donnell's levator function is normal, he has no levator weakness and no ptosis. He does have dermatochalasis of both eyelids but it causes no interference with vision. Respondent's conduct in diagnosing ptosis constitutes gross negligence.

25. Patient B.C.

B.C. was 76 years old when she was examined by respondent on October 23, 1991. Due to a stroke she was living in a nursing home confined to a wheelchair. B.C. complained of poor vision, trouble with colors, dry, itching, and watery eyes sensitive to light. Respondent diagnosed her as having 3+ nuclear sclerosis cataracts in both eyes, describing them as "dense". Respondent recommended surgery for both eyes and B.C. was scheduled for right eye surgery on November 7, 1991.

Respondent's conduct in diagnosing dense cataracts and recommending immediate surgery for B.C. constitutes negligence. B.C. had best corrected vision of 20/40 in both eyes. Vision problems in her right eye were caused by chronic lid margin changes. She had an early nuclear sclerosis cataract with slight color change and minimal visual significance in her right eye; she had macular degeneration and an early cataract in the left eye. Surgery would not improve the patients vision and her physical condition was such that surgery was too much of a risk without any perceptible benefit.

Respondent caused false information about the severity of the patient's cataracts to be placed in her chart.

26. Patient Jones

Jones was a 57 year old real estate appraiser when he went to respondent on March 17, 1992, for his yearly check up and a new glasses prescription. He had always worn glasses but recently felt his vision was not as clear as it should be. He was examined by a technician who improperly administered the BAT test by using only the high setting and who told him the test would determine if he had cataracts. Jones best corrected vision was 20/20 in both eyes. Respondent examined Jones and diagnosed ptosis and teardrop cataracts in both eyes. He told Jones he would need new glasses every 6 months and recommended cataract surgery to avoid that problem. Neither respondent nor the

surgical counselor discussed any risks or alternatives to surgery with Jones. On April 16, 1992, Jones had cataract surgery on his left eye. Right eye surgery was postponed due to the pending disciplinary action. Complainant presented no expert testimony to establish the actual condition of Jones' eyes.

Respondent knowingly caused a document to be given to Jones and placed in the chart which falsely stated his vision was borderline or below the DMV standard for driving. This conduct constitutes negligence, dishonesty in the practice of medicine and creation of false medical records.

27. Patient Espino

Espino was 44 years old when she saw respondent on April 17, 1992. She felt she needed new glasses because after reading a lot her eyes became tired, watery and blurry. She complained of her vision being worse in her left eye. Respondent examined Espino and told her he was going to make her see without glasses. He told her he saw a cloud in her left eye and it was going downhill. He told her he would perform surgery on her left eye first and then her right eye. He did not tell her she had cataracts, nor did he explain her condition or discuss any alternatives to surgery or risks of surgery. In the chart respondent noted findings of "lens opacities, left greater than right". Although he did not note a diagnosis of cataracts, his recommendation is cataract surgery on the left eye.

Respondent sent Espino to the surgical counselor who scheduled surgery for April 30, 1992. The counselor was in a hurry and did not explain the surgical procedures or give Espino a chance to ask questions. Espino was not given the first two pages of the consent form which explained risks and alternatives; the counselor merely put the signature page in front of her and said "just sign here". After getting a second opinion Espino decided not to have surgery.

Respondent knowingly caused false entries to be placed in the chart indicating the surgical procedure had been explained to the patient, risks and alternatives discussed and patient questions. Respondent knowingly caused a document to be given to Espino which falsely represented her visual acuity and falsely indicated her vision was borderline or below the DMV standard for driving. These false representations were made for the purpose of justifying and encouraging surgery.

Espino's best corrected vision is 20/15 in both eyes and her reading vision is correctable with bifocals. Both lenses are clear; she has a few cortical snowflake opacities but nothing of visual significance. The poor vision in her left eye is caused by astigmatism and the blurry vision was caused by refractive error.

Respondent's treatment of Espino constitutes an extreme departure from the standard of care. He recommended and encouraged surgery for a patient who merely needed new glasses. He failed to discuss risks and alternatives to surgery.

28. Patient Britt

Britt was 67 when she went to respondent for an eye examination on March 26, 1991. She was having problems reading piano music and also wanted to be checked for glaucoma. She was examined by a technician and her best corrected vision was found to be 20/25 right eye and 20/20 left eye. The chart notes a diagnoses of cataracts and recommends a check up in three months. On June 25, 1991, Britt was again examined for cataracts. The technician told her she had small cataracts but the chart notes reflect a diagnoses of 3+ nuclear sclerosis cataracts in both eyes. Respondent advised Britt that surgery could be done because it causes less damage to remove cataracts when they are small. He also discussed having eyelid surgery and entered a finding of levator disinsertion next to the eyelid drawing in her chart. Respondent next examined Britt in September, 1991, he told her the cataracts had grown and discussed doing surgery.

In November 1991, Britt felt her vision was fine with glasses and she had no problems doing any activities. At completion of her eye examination on November 6, 1991, respondent sent Britt to the surgical counselor. He did not tell her he was sending her to the counselor to schedule surgery. He did not advise Britt of any alternatives to surgery nor did he discuss any risks. The surgical counselor did not discuss any risks or alternatives before scheduling surgery for November 14, 1991. Britt allowed surgery to be scheduled because respondent had been telling her the cataracts were growing and eye pressure increasing and she was afraid if she did not have the surgery she would have serious problems. Britt obtained a second opinion and canceled the surgery. Complainant presented no evidence by way of expert testimony to establish the actual condition of Britt's eyes. However, she obtained new glasses and with them her vision is fine. She has no problem reading music, seeing highway signs or with night vision. Respondent's conduct in recommending and encouraging surgery without advising Britt of any risks or alternatives constitutes gross negligence.

Respondent caused an entry to be made in Britt's chart on November 6, 1991, stating that her vision was borderline or below the standard to drive an automobile. Although she was given the document stating this, respondent told her he would not disqualify her from driving. This made Britt believe her vision was too poor to drive and she felt uneasy. Respondent's conduct constitutes dishonesty and the creation of false medical records.

29. Patient Boyle

Boyle was 73 years old when respondent performed cataract surgery in September and December 1990. Complainant presented no expert testimony to establish the surgery was not medically indicated.

Boyle was not having trouble with his eyelids and did not tell respondent or his staff his lids were droopy or blocking his vision. Respondent's technician told Boyle his lids were drooping and blocking his vision. On January 2, 1991, respondent recommended Boyle have ptosis surgery. Boyle agreed to the surgery only because the technicians told him his eyelids had to be interfering with his vision and he needed them fixed. After surgery Boyle could not notice any difference in vision.

Respondent knowingly caused false entries to be made in Boyle's chart for dates October 26, 1990, November 7, 1990, and January 2, 1991, indicating the patient had made specific complaints about his eyelids interfering with his vision and that ptosis surgery was Boyle's choice.

30. Patient Costa

Costa was a 62 year old business and education consultant and adjunct professor who had been seeing respondent for annual check ups for 10 years. During his annual visit on April 12, 1991, respondent diagnosed cataracts in both eyes that did not yet need surgery and gave a new glasses prescription. In March, 1992, Costa felt his vision was fine; he had no problems reading or with glare at night or during the day, no blurry vision and he drove extensively at night. He saw respondent on March 10, 1992, for his annual checkup. Respondent diagnosed 3+ nuclear sclerosis cataracts in both eyes and recommended surgery be done in the near future because of possible complications but did not explain the complications. Respondent told Costa of other patients who were pleased with the cataract surgery. The technician improperly administered the BAT test using the high setting. Costa did not complain of any vision problems, nor did he say he had any trouble night driving or seeing street signs. The technician said "You're really having trouble seeing at night with the glare of headlights", and Costa responded he was not. Costa decided to have cataract surgery because he was scared by respondent's warning there could be complications if he waited longer and feared losing his sight. Respondent did not discuss any risks or alternatives of surgery.

Costa was immediately sent to the surgical counselor who scheduled surgery on the right eye for April 9, 1992. The counselor gave him a consent form to sign but only about two minutes to read it. Costa had no questions or concerns about

risks of surgery because respondent told him about the benefits and he trusted him.

Costa had surgery on his right eye as scheduled. Complications developed and another surgical procedure was done on April 16, 1992. Left eye surgery was cancelled due to the pending disciplinary action. Costa did not have further surgery and his vision is now the same as before his treatment.

The findings and notes in respondent's chart falsely state the condition of Costa's eyes. His left eye vision is correctable to 20/25 and near vision is correctable to J-1. The lens has only a trace cataract. Based on Costa's history and symptoms there was no medical indication for the cataract surgery performed in April, 1992. Respondent's recommendation of cataract surgery on the left eye constitutes an extreme departure from the standard of care because the patient had no vision problems and he was not having trouble with any of his activities.

Respondent knowingly made or caused to be made false entries in Costa's chart regarding the patient's visual complaints, his visual acuity, and the condition of his lenses and the need for cataract surgery.

31. Patient Beets

Beets was 67 years old when respondent performed cataract surgery on his left eye on August 22, 1991. Beets had been treated by respondent for several years for problems with diabetic retinopathy, macular edema and macular degeneration. Beets had decreasing vision in his left eye and had to stop driving because of headlight glare problems. After the cataract surgery his vision improved and he could see in any light. It was not established this surgery was unwarranted or poorly performed.

Respondent did not discuss any risks of the cataract surgery with Beets. Mrs. Beets was concerned about her husband's medical condition and, while in the examining room, asked about risks of surgery and anesthetic. Respondent replied he operated on many elderly people and prayed for his patients; he said his patients got along fine and Beets would have no problems. When respondent left the room, Mrs. Beets asked the technician about risks of cataract surgery. The technician said, "With Dr. Rutgard there are no risks." Mr. and Mrs. Beets asked the surgical counselor if there was any risk to the surgery and she replied "There are no risks with Dr. Rutgard." Mrs. Beets questioned the counselor about the anesthesia that would be used and the only reply given was "You don't have to worry with Dr. Rutgard". Beets wanted to have surgery in a hospital and

complained to the counselor that the statement on the consent form that he was given that option was not true. The counselor advised Beets respondent did surgery only at his office and the form was standard and must be signed if he wanted surgery. Mr. and Mrs. Beets found it very hard to get any information from respondent's office about the cataract surgery. Beets was not given any written material describing alternatives and risks of surgery. They finally had to have Beets' internist call respondent to get assurance that only a local anesthetic would be used.

When respondent performed the cataract surgery he also performed an astigmatic correction on the left eye. Neither respondent nor his staff advised Mr. or Mrs. Beets such a procedure might be done. The procedure is not mentioned on any of the purported consent forms signed by Beets. After surgery Beets was not told the astigmatic correction had been performed. Beets had read about the procedure and would not have consented to it. Beets learned the procedure had been done only after being examined by another ophthalmologist. Respondent's conduct in performing a surgical procedure without advising the patient about it and obtaining consent constitutes an extreme departure from the standard of care.

Respondent knowingly caused entries to be placed in the patient's chart falsely stating the risks of surgery had been discussed and questions answered. Respondent knowingly allowed his employees to falsely represent to Beets that there were no risks to cataract surgery. Respondent's failure to advise the patient of the risks and alternatives to cataract surgery constitutes gross negligence.

After the left eye surgery respondent recommended surgery on the right eye very soon because the cataract was getting harder. Respondent diagnosed the cataract as 3+. Beets' postponed surgery due to ill health and he ultimately sought a second opinion on the advice of his internist. As of September, 1991, Beets had only a trace nuclear sclerosis cataract in his right lens, it was an early lens change with some few peripheral cortical changes which is common in diabetics. It was a severe retinal problem, not the cataract, that was interfering with Beets' right eye vision. By September, 1992, Beets had suffered a general systemic deterioration and the cataract was 3+. Complainant's evidence is not clear and convincing that there was no medical indication for recommending cataract surgery on the right eye in August, 1991.

/
/
/
/
/
/

32. Patient Flanders

Flanders was 78 years old when he first became a patient of respondent in June, 1988. At that time respondent performed ptosis repair surgery on both eyes. In September, 1991, Flanders went to respondent for a routine exam to see if he needed new glasses. His eyes did not bother him but he felt he had a slight vision problem and probably needed new glasses. A technician examined his eyes and told him he had cataracts. When he expressed surprise, the technician said respondent would examine him and tell him the same thing. Respondent knowingly employed an unlicensed person to examine the patient and diagnose a medical condition.

Respondent examined Flanders and said he had cataracts and needed surgery right away. Flanders vision was not interfering with his regular activities and no one in respondent's office asked if it was. Flanders told respondent he was caring for his ill wife and could not take the time for surgery. Respondent then recommended and performed laser iridectomies on both eyes. The medical indication for this procedure is glaucoma but Flanders did not have glaucoma. Immediately after the laser surgery Flanders began to experience pain and an intermittent filminess in the left eye. Respondent advised him it would go away.

Flanders continued to have pain in the eye. He saw another doctor who became concerned about a possible retina problem and referred him for a second opinion. In November, 1991, Flanders was examined by Dr. Gelber, a retina specialist, who found his best corrected vision to be 20/25 in the right eye and 20/40 in the left. Flanders had very early lens changes in both eyes, in the range of 0 to 1 stage cataracts, typical for an 81 year old man. The cataracts were not significant enough to interfere with his functional vision and Flanders presented no complaints to indicate any problem. Flanders did have retinoschisis (splitting of the retinal layers) in the left eye. Dr. Gelber tested the visual fields and found the retinoschisis did not cause any significant problem with peripheral vision and there was no visual impairment from lid ptosis. He informed Flanders the schisis did not then require treatment. He also advised against cataract surgery because Flanders did not need it and because of the risk to the left eye. Flanders returned to respondent and told him of Dr. Gelber's opinion. Respondent said Dr. Gelber was wrong and did not know what he was talking about. Respondent insisted cataract surgery was necessary. Based on respondent's recommendation, Flanders agreed to have the surgery. He thought because respondent had so many patients his opinion was more reliable.

On December 26, 1991, Flanders had cataract surgery on the left eye. A week after surgery, he had throbbing pain in the

eye and could not see. Respondent merely said the eye would heal eventually and on January 2, 1992, he performed cataract surgery on the right eye. Immediately after this surgery respondent told Flanders that he should return for ptosis surgery so he could see better. Flanders was having no problems with his eyelids and reminded respondent that he had already done the lid surgery in 1988. Respondent replied that he would perform a different, very simple operation where he just took a couple of stitches in the lids.

On a February, 1992, visit to respondent's office the technician became concerned about the condition of Flander's left eye and referred him to Dr. Poliner, a retina specialist who diagnosed a retinal detachment in the left eye and performed surgery to repair the condition. By July, 1992, Flanders visual acuity was apparently stable at 20/20 right eye and 20/80 left eye. Flander's right eye vision is now about 50% worse than before respondent performed cataract surgery.

Respondent's cataract surgery on Flanders constitutes an extreme departure from the standard of care because the surgery was not medically indicated and, without need, he subjected the patient to a known and serious risk of further problems with his left eye. In his treatment of Flanders, respondent employed an unlicensed person to examine him and diagnose cataracts. Respondent's recommendation of ptosis surgery on a patient who did not need it constitutes gross negligence.

Respondent knowingly authorized or made false entries in Flander's chart under "physician notes" for December, 1991, stating the patient complained of decreased vision interfering with his daily activities. Respondent knowingly authorized or made false entries in Flanders' chart on February 17, 1992, stating the patient complained of droopy eyelids getting worse and interfering with his activities.

33. Patient FDLR

FDLR was 69 years old when she was referred to respondent by the CR department on April 2, 1991. She did not speak English. Respondent found her best corrected vision to be 20/25 right eye and 20/20 left eye, with a BAT score on high setting of 20/50. He diagnosed cataracts in both eyes and ptosis and scheduled cataract surgery for April 11, 1991. On that date, FDLR's daughter, a nurse, took her to another ophthalmologist for a second opinion. Examination confirmed best corrected vision of 20/20 and 20/25 and revealed she had early cortical sclerosis and early nuclear sclerosis cataracts in both eyes along with minimal macular degeneration. The cataracts were not visually significant and any decreased vision was caused as much by the

macular degeneration as by the lens changes. FDLR's vision was not interfering with her daily life, she felt her vision was fine and she could read and watch TV without difficulty. FDLR did not have the surgery.

It was an extreme departure from the standard of care for respondent to recommend and schedule cataract surgery for FDLR because there was no medical indication for the surgery. FDLR did not have visually significant cataracts, her life style was not affected by any decreased vision and she did not feel she had a vision problem.

34. Patient McKelvey

McKelvey was first seen by respondent in 1988 when she needed reading glasses. At that time she had no problems with blurred vision, glare, light sensitivity or distance vision. Respondent said nothing about cataracts and did not make any diagnosis of cataracts. She next saw respondent in April and May of 1991, for treatment of a scratched cornea. In October, 1991, she returned for a vision check up after getting a reminder card from respondent's office. She felt she needed reading glasses but had no problem with distance vision. Her business required a lot of driving, both day and night, and she was not having any problems with it. Respondent did not say she had vision problems driving or seeing street signs. Upon examination, her best corrected vision was 20/20 in both eyes. Respondent told her she had cataracts in both eyes and needed surgery, that without surgery she would be wearing "coke bottle" glasses within a year. No one gave her any information about cataracts, explained what they were, or explained the surgery and why it was appropriate. She asked respondent about the risk of surgery and he replied it was no more than driving on the freeway. McKelvey decided to have the surgery.

On October 31, 1991, respondent performed cataract surgery on her right eye. A week after surgery her right eye vision was very poor and she developed a widely dilated pupil. On November 7. 1991, respondent performed a Miostat injection to try to constrict the pupil. Despite the continuing problem with her right eye, respondent recommended McKelvey proceed with surgery on the left eye. The left eye surgery was scheduled but she cancelled it. McKelvey's right eye vision remains poor, she describes it as "looking through water", and it is so sensitive to light she wears sunglasses most of the time.

Respondent's conduct in diagnosing cataract in the left eye and recommending and urging surgery on that eye constitutes gross negligence. The lens of McKelvey's left eye was clear and without cataract formation. There was no medical indication for the surgery. Respondent's failure to advise McKelvey of the

nature of the surgery, its risks and alternatives to surgery constitutes gross negligence.

Respondent knowingly authorized or made false entries in McKelvey's chart. On October 28, and November 1, 1991, false entries were made stating McKelvey complained of decreased vision interfering with daily activities including driving and seeing street signs, and she had cataracts consistent with these complaints. In order to convince McKelvey to have surgery, respondent made false representations to her about the need for surgery, the absence of risk, and that her vision was below the DMV standard for driving.

35. Patient Walsh

Walsh became a patient of respondent in April, 1986, when she needed new glasses. The chart entry for that date indicates 2+ nuclear sclerosis cataracts in both eyes. She returned for a new prescription in July, 1990, at which time respondent diagnosed 3+ nuclear sclerosis cataracts in both eyes and told Walsh she would need surgery when the cataracts got "ripe". She was given a BAT test on the high setting which indicated vision of 20/400 right eye and 20/200 left eye. Walsh was 69 years old when she returned for her next examination on April 24, 1991. She was experiencing some eye strain in her work as a typist and lights bothered her a little bit when she was driving at night. She was worried her cataracts might be worse and did not want them to get "over ripe". Her best corrected vision was 20/25 in both eyes. She was given a BAT test on the medium setting which indicated vision of 20/60 in both eyes. Respondent again diagnosed 3+ cataracts and recommended surgery. He represented to Walsh her vision was below the DMV standard for driving. On June 6, 1991, respondent performed cataract surgery on the right eye. Left eye surgery was scheduled for August. Walsh was not happy with the result of the right eye surgery; near vision had improved but not distance vision. Respondent advised her that her eyes were out of focus and the problem would resolve after left eye surgery.

On July 17, 1991, Walsh was examined by Dr. Joseph Michaelson for a second opinion. He found a trace nuclear sclerosis cataract in the left eye and a wrinkled implant in the right eye. The right eye had perfect near vision and was correctable to 20/15 for distance. The left eye was farsighted and had uncorrected vision of 20/15. He found Walsh's vision to be well within the DMV standard for driving. He gave her a new glasses prescription which resolved her vision problems. Walsh had no need for cataract surgery on her left eye and she canceled the scheduled surgery. On August 2, 1991, respondent wrote Walsh, expressing disappointment over the cancellation and urging her to reconsider. He made false statements, indicating her BAT

results were very poor at 20/400 in each eye and that the high Bat setting used simulated the normal lighting in California.

Respondent's conduct in diagnosing a 3+ nuclear sclerosis cataract in the left eye and in recommending and urging surgery constitutes negligence because she had only a trace cataract and her vision problem was correctable with glasses.

Respondent knowingly made false representations to Walsh about the results and meaning of the BAT examination in order to convince her to have surgery. Respondent knowingly authorized or made false entries in Walsh's chart indicating that her vision was below the DMV standard for driving.

36. Patient Norton

Norton was 71 years old when she first saw respondent for an exam in 1989. Respondent diagnosed cataracts and prescribed new glasses. In June, 1991, Norton received a card from respondent for a free eye examination. At that time she felt her vision was fine, she drove at night without problem and had no problem with glare or seeing street or freeway signs. Her vision was not interfering with any daily activities. She went to respondent because she wanted the free exam. She was examined by respondent on June 5, 1991. He told her the cataracts were ready for surgery and sent her to a counselor to schedule a date. He did not discuss whether or not she had any vision problems but merely said, "Wouldn't it be nice to see without glasses?". She did not agree to have surgery but felt swept off her feet when he immediately sent her to the counselor. The counselor spent about ten minutes with Walsh and set surgery for August 15, 1991. Norton felt respondent was pushing her into surgery so she saw another ophthalmologist for a second opinion.

Norton was examined by Dr. Robert Goldman on July 17, 1991. She had minor cortical cataracts in both eyes which were minor opacities but nothing of visual significance. Her best corrected vision was 20/25 in both eyes.

Respondent's conduct in recommending cataract surgery constitutes gross negligence because there was no medical indication for the surgery. Norton was satisfied with her vision and the cataracts were so insignificant there would be no appreciable improvement with surgery. The surgery would only expose her to potential risks and complications without benefit to her.

Respondent knowingly authorized or made false entries in Norton's chart indicating her best corrected vision was 20/50 and 20/40 and her real life functional vision was 20/80 and 20/70 as determined by the BAT test.

37. Patient Philippi

Philippi was 65 years old when she became a patient of respondent in 1988. At that time respondent diagnosed cataracts. Philippi was again examined by respondent in September, 1989; her best corrected vision was 20/20. In October, 1990, she saw respondent who found her best corrected vision to be 20/25 in both eyes. She was given a BAT test only on the high setting which indicated vision of 20/80 and 20/300. Respondent again diagnosed cataracts. In March, 1991, Philippi was having vision problems which made it difficult for her to do her quilting. She knew she had recent macular degeneration in her left eye which distorted her vision. Upon examination her best corrected vision was 20/20 right eye and 20/40 left eye. Respondent told her she had macular degeneration and cataract surgery was necessary. He advised that the surgery would not help with the macular degeneration but would help her see better. He did not say glasses were an alternative and she felt there was no choice because respondent told her she had to have surgery. Philippi obtained a second opinion and decided not to have surgery.

On April 15, 1991, Philippi was examined by Dr. Nicholas Zubyk who confirmed the best corrected vision of 20/20, 20/40 and found significant macular degeneration in the left eye. Philippi had trace nuclear sclerosis cataracts which did not affect her vision. There was no medical indication for cataract surgery because her vision loss was caused by a retina problem, not the cataracts.

Respondent's conduct in recommending cataract surgery to Philippi constitutes gross negligence because there was no medical indication for it.

38. Patient Morales

Morales was 75 years old in March, 1990, when he was examined by the CR department technician at the Mira Mesa Senior Center. He could not see well and had not driven since 1977 because of his vision. He thought he had cataracts. The technician told him he had cataracts and an appointment was made to see respondent. Morales was examined by respondent on March 19, 1990. The chart contains no entry to indicate best corrected vision. Respondent diagnosed cataracts and ptosis. Morales agreed to have cataract surgery. On about April 1, 1990, respondent performed cataract surgery on the right eye. Surgery on the left eye was not performed until January, 1992. No evidence was presented regarding the reason for delay. Morales' vision improved after the surgery.

A technician asked Morales if he was interested in fixing his eyelids and he said no. No one asked if his eyelids

were affecting his vision. He did not tell anyone that his lids were too heavy, that they came down and he couldn't see or that he had to hold them up. He never agreed to have surgery done on his eyelids. Respondent made entries in the clinic and surgery chart in March, 1990, and again in February and April, 1992, purporting to reflect Morales complaints about his eyelids drooping and interfering with his vision. These chart entries are false and were made by respondent for the purpose of justifying ptosis surgery. Respondent performed internal ptosis repair surgery on both eyes on March 6, 1992. Morales was scheduled for "Blepharoptosis repair with lateral canthopexy" to be performed on April 27, 1992. Complainant presented no evidence to establish whether or not there was medical indication for the surgery performed or the surgery scheduled.

39. Patient Mr. Hamrick

Hamrick had glaucoma and saw respondent in July, 1991, for treatment of that condition. A technician examined him and told him he had a large cataract in the left eye and a high ocular pressure. Respondent examined Hamrick and told him he had cataracts in both eyes and severe glaucoma. Respondent recommended cataract surgery as soon as possible but first performed a laser treatment to reduce the eye pressure. Hamrick was not having any trouble driving, seeing street signs, reading or watching TV. His vision was not interfering with his daily activities. Neither respondent or his staff advised Hamrick of any risks of cataract surgery. Complainant presented no expert testimony about the condition of Hamrick's eyes.

Respondent's failure to advise Hamrick of the risks and alternatives of surgery constitutes gross negligence. Hamrick's chart contains several "PARDISC" entries which are false. This constitutes dishonesty and the creation of false medical records.

40. Patient Mrs. Hamrick

Complainant did not present sufficient evidence to establish the allegations and charges set forth at pages 38 and 39 of the Third Amended Accusation relating to Mrs. Hamrick.

41. Patient Jett-Carroll

Jett-Carroll is thirty-two years old and has been seeing respondent for occasional eye exams since about 1984. She was examined by respondent on October 30, 1991, for her annual eye exam. She has always had a problem with her left eye which she cannot turn to the left and she felt the eyelid drooped more than on the right eye. She did not tell respondent her lids were

heavy and tired and blocking her vision. The lids did not block her vision, did not cause a problem driving and she did not tell respondent her vision interfered with her ability to drive. Respondent did not tell her the lid was affecting the safety of her driving. Respondent lifted both of her lids with his fingers and asked if she could see better; she answered yes. Respondent diagnosed amblyopia and ptosis, noting in the chart "levator weakness" greater in the left eye than the right. Respondent recommended she have excess skin removed from the lids so she could see better. Respondent took two pictures of Jett-Carroll to send to the insurance company for surgery authorization. As a result of his instructions Jett-Carroll lowered her lids more than their normal appearance for the picture. She decided to have surgery and scheduled it for April 24, 1992.

On November 20, 1991, respondent sent a letter to Jett-Carroll's insurance company in which he states, "she stated that her eyelids were heavy, tired and blocking her vision especially noted in driving". The letter also states the patient's eyelids were affecting the safety of her driving, and "actually impairing her vision". Respondent further represented she had a markedly weak levator muscle function, the lids covered over 50% of her pupillary axis and she had a marked superior visual field restriction in both eyes. All of these representations to the insurance company were false and respondent knew or should have known so. The purpose of this letter was to obtain payment by the insurance company for the surgery. On April 3, 1992, the insurance company approved the surgery.

On April 19, 1992, the purported result of a confrontational visual field test was placed in the chart which indicated a significant loss of superior vision. This visual field is false and does not reflect the actual condition of Jett-Carroll's vision. Respondent also caused to be placed in the chart a form listing the surgery to be performed and the indications for the procedure. The form indicated the patient complained of droopy eyelids getting worse and interfering with her daily activities. Respondent knowingly made or authorized false entries in Jett-Carroll's chart regarding her complaints and the condition of her eyelids, and did so for the purpose of justifying the surgery.

Jett-Carroll did not have surgery and on August 5, 1992, she was examined by another ophthalmologist for a second opinion about her ptosis condition. She does not have ptosis in either eyelid and there is no levator weakness. Both eyelids are in correct anatomical position but there is a slight asymmetry in the lid fissure. The lids do not cover 50% of the pupillary axis and do not affect her driving. Jett-Carroll does have a condition in the left eye known as Duane's syndrome which prevents her from looking to the left and causes the appearance of a ptosis in the left lid when she looks to the right. Jett-

Carroll does have excess skin on both lids which touches the eyelashes and a cosmetic blepharoplasty would be an appropriate procedure. However, there is no medical indication for ptosis repair surgery and respondent's diagnosing, recommending and scheduling of it is an extreme departure from the standard of care.

42. Patient E.M.

E.M. is 76 years old and has been a patient of respondent for several years. E.M. was scheduled to have ptosis repair surgery by respondent on April 27, 1992, but it was cancelled due to the pending disciplinary action. This surgery was not medically indicated. On July 16, 1992, E.M. was examined by an ophthalmologist who found normal levator muscle function with lids that moved up and down properly. There was no levator disinsertion or dehiscence and no levator weakness. The lids were in appropriate positions on the eyes and did not obstruct vision. E.M. had no complaint about his eyelids or any interference with his visual field.

The entries in E.M.'s chart for April 17, 1992, relating to the condition of his eyelids, including the visual field test, are false and do not accurately reflect the patient's condition. These entries were made by respondent or with his authorization in order to justify the ptosis surgery.

Respondent's conduct in recommending and scheduling surgery for E.M. constitutes an extreme departure from the standard of care.

43. Patient Bebbington

Bebbington was 76 years old in 1988 when he was examined by a CR department technician at his seniors residence and referred to respondent. Respondent performed cataract surgery and wound revision in 1991. On August 28, 1991, respondent examined Bebbington, found levator weakness and diagnosed ptosis. On April 13, 1992, respondent examined him and made the following entry in the chart regarding the patient's complaint: "c/o my lids are cutting off my vis, when I hold them up I see better". In fact, Bebbington was not having any problem with his lids nor did he feel they were interfering with his vision. He did not tell respondent he had a problem or he had to hold up his lids. Respondent found mild levator weakness, made a diagnosis of ptosis and recommended Bebbington have surgery. Respondent told him if the lids were raised he would have better vision. Bebbington agreed to have surgery on April 27, 1992, because he believed respondent knew what he was doing.

Bebbington did not have the surgery and was examined by an ophthalmologist in July, 1992. He was found to have middle disinsertion of the levator aponeurosis resulting in ptosis of the lids with good levator function. While he probably experienced a small loss of superior visual field he did not complain of any symptoms. It was a departure from the standard of care to recommend and schedule ptosis surgery for this patient who suffered no symptoms and had a condition which did not cause harm.

Respondent knowingly made a false entry in the chart on April 17, 1992, about the patient's complaint and did so in order to justify the surgery.

44. Patient Dibble

Complainant did not present sufficient evidence to establish the allegations and charges set forth at pages 54 and 55 of the Third Amended Accusation relating to patient Dibble.

45. Patient Krause

In March, 1992, Krause responded to a card sent by respondent offering a free eye examination. He was examined by technicians who told him he had cataracts in both eyes which would prevent him from passing the DMV eye test. They advised him to schedule surgery within the next couple of weeks because his eyes were in a dangerous condition. Krause insisted on seeing respondent before he scheduled surgery.

Krause was 71 years old and not having any problem with his vision. He wore only reading glasses, had no trouble with driving or day or night glare, and had no difficulty seeing street or freeway signs. He did not tell the technicians he was having any vision problems. Krause's best corrected vision was 20/20 in both eyes. He had a 1+ nuclear sclerosis cataract with one small spoke in the right eye and a 1+ nuclear sclerosis cataract in the left eye. His decreased vision was correctable with a new prescription.

Respondent knowingly employed unlicensed persons to examine the patient, diagnose a medical condition and recommend surgical treatment. It was an extreme departure from the standard of care to recommend cataract surgery for Krause because it would subject him to the risk of the procedure without medical indication.

/
/
/
/

46. Patient Strauser

On April 24, 1991, Strauser was given a free examination by CR department technicians at her seniors residence. At that time she wore reading glasses but did not feel she had any vision problems. She could read and drive and her vision was not a problem in any of her daily activities. After the examination, Cherie Burks, the director of the CR department, told Strauser she had cataracts in both eyes and advised her to see respondent. Burk also advised Strauser her left eyelid was droopy and should be corrected. On June 7, 1991, Strauser went to respondent's office and was examined by two technicians who told her she had cataracts that should be taken care of. She did not see respondent on that date. She returned for another visit on about June 10, 1991, and was again examined by the same technicians and respondent. The technician told her if she had surgery she would no longer need glasses. No one asked her if she had any problem seeing things and she did not complain of any problems driving or with glare. No one advised her that vision could be worse after surgery. Surgery on the left eye was scheduled for June 13, 1991. Strauser was not seen by the surgical counselor or given any information or documents about the surgery. She was told documents would be mailed to her but she did not receive any. She was given a consent form to sign about fifteen minutes before the surgery and was not given time to read any documents. A nurse told her she was to have laser surgery and if cataracts were found they would be removed. Respondent performed cataract surgery on Strauser's left eye on June 13, 1991. There were complications and her left eye vision is now so poor she has problems reading and driving. Strauser canceled the cataract surgery on her right eye which was scheduled for July, 1991.

Respondent knowingly employed unlicensed persons to examine the patient, diagnose a medical condition and recommend treatment. On June 10, 1991, he knowingly made a false entry in her chart under "physician notes" stating the patient complained of decreased vision interfering with her daily activities including driving and seeing street signs.

47. Patient Druckman

Druckman went to the La Jolla office in the spring of 1991 in response to respondent's newspaper ad for free glaucoma screening. He was examined by a technician who said he had acute glaucoma and needed surgery soon. She advised him laser surgery could be done and directed him to the front desk to make an appointment. Druckman was never examined by respondent or any other physician. The technician did not suggest he be examined by respondent or any physician. Druckman did not schedule any surgery by respondent.

Respondent knowingly employed an unlicensed person to examine the patient, diagnose a medical condition and recommend treatment.

48. Patient Griffen

Griffen is 47 years old and has worn glasses since childhood. In 1991, he was experiencing eye strain and needed bifocals. He was referred to respondent by a friend who had undergone a successful radial keratotomy. Griffen was interested in surgery so he would no longer need glasses. Respondent examined Griffen in November, 1991, and found his best corrected vision to be 20/25 in both eyes. Respondent told Griffen that because of the degree of his astigmatism, he was not the ideal candidate for the surgery but could expect at least 80% reduction in astigmatism, he might have to wear reading glasses and his quality of life would improve tremendously. On March 6, 1992, respondent performed the radial keratotomy on both eyes. After the post operative period and many follow up visits, Griffen continued to have blurry vision and headaches. Respondent referred him to another ophthalmologist who, after examining Griffen and reviewing respondent's charts, found respondent had performed the surgery planned for the right eye on the left and vice versa. As a result Griffen is now farsighted and has a significant difference in refraction between the eyes. This causes headaches and difficulty focusing near vision. Because of the amount of surgery done by respondent, no further surgery can be done without a high risk of making the vision worse.

Respondent's conduct in performing the wrong surgery on each eye constitutes an extreme departure from the standard of care.

49. Patient Mouser

Mouser was 78 years old when he first saw respondent in July 1991. Cataracts had been diagnosed by another physician and Mouser had already had surgery on the left eye. He had very poor vision in the right eye. Respondent examined him and recommended cataract surgery. He explained the surgery and discussed alternatives. Mouser was already familiar with the surgery and possible complications.

On July 11, 1991, respondent performed cataract surgery on the right eye. Within two weeks after the surgery respondent discovered he had implanted a lens of the wrong power. He informed Mouser he had implanted the wrong lens and on August 1, 1991, respondent performed surgery to correct the mistake. Mouser's vision was then exceptionally better.

Complainant presented insufficient evidence to establish the charges relating to patient Mouser.

50. Patient Darwin

Darwin was 62 years old and wheelchair bound when he came to respondent through the CR department in March, 1992. In his own words, he "couldn't see doodly" and was running into walls, curbs and cars with his wheelchair. He definitely wanted cataract surgery done on both eyes and was not concerned about the risk of losing vision because, again in his own works, "I was blind". On March 25, 1992, respondent examined Darwin and directed that cataract surgery be performed on the right eye first, then the left. Darwin signed a form authorizing cataract surgery on his right eye and the surgery was scheduled for April 2, 1992.

For reasons unknown, on the day of surgery Darwin's left eye was prepped and anesthetized. When he was brought into the operating room one of the nurses noticed the mistake. Since the patient was already prepared, she changed the surgery chart to reflect surgery to be done on the left eye. Respondent was informed of this error before he sat down to do surgery. He reviewed the chart and the implant calculations and decided that since he was planning to do the left eye anyway, he would go forward with the surgery. Respondent performed surgery on the left eye but did not inform Darwin of the mistake.

The Authorization Form and Consent to Surgery signed by Darwin, the Surgery Schedule Checklist, and the chart Worksheet/Checklist for informed consent were altered to make it appear the left eye was intended to be the surgical eye on April 2, 1992. This was done either by respondent or with his knowledge and consent. On April 8, 1992, Darwin scheduled the next cataract surgery and was given an authorization form to sign which indicated surgery would be performed on his left eye. Right eye surgery was never performed on Darwin.

Respondent's conduct constitutes the creation of false medical records and dishonesty in matters relating to the practice of medicine.

51. No evidence was presented regarding mitigation or rehabilitation. Respondent may very well be a good eye surgeon. He purported to promote cataract and eyelid surgery because he believed it would help people see and live better. However, the evidence is clear and convincing that by 1990, respondent lost all sight of his professional responsibility; his motivation became profit, not patient care. This was communicated in direct and subtle ways to staff and permeated their conduct and

decisions. Under respondent's leadership his practice was transformed into a surgery assemblyline where patients were processed in a highly efficient and profitable but extremely fraudulent and dangerous manner. Regardless of his motivation, respondent abused his position of trust and acted in such an egregiously unprofessional and unethical manner, with such scant care for the real interests and welfare of patients that he has forfeited any right to practice medicine.

52. With regard to allegations and charges in the Third Amended Accusation which are not specifically addressed in Findings 3 through 51 above, complainant failed to present evidence that was sufficiently clear and convincing to prove the charges.

DETERMINATION OF ISSUES

I

Cause was established to discipline respondent's license pursuant to Business and Professions Code section 2227 for violation of section 2234(b), gross negligence, by reason of Findings 5, 6, 7, 8, 9, 11, 12, 15, 17, 20, 21, 22, 23, 24, 26, 27, 28, 30, 31, 32, 33, 34, 36, 37, 39, 41, 42, 45, 48 and 51.

II

Cause was established to discipline respondent's license pursuant to Business and Professions Code section 2227 for violation of section 2234(c), repeated negligent acts, by reason of Findings 6, 7, 10, 20, 22, 25, 31, 32, 35, 43 and 51.

III

Cause was established to discipline respondent's license pursuant to Business and Professions Code section 2227 for violation of section 2234(e), commission of acts involving dishonesty or corruption which are substantially related to the qualifications, functions and duties of a physician, by reason of Findings 10, 11, 12, 14, 16, 20, 21, 22, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 38, 39, 41, 42, 43, 46, 50 and 51.

IV

Cause was established to discipline respondent's license pursuant to Business and Professions Code section 2227 for violation of section 2261, knowingly making a document directly related to the practice of medicine which falsely represents the existence or non-existence of a state of facts, by reason of Findings 10, 11, 12, 14, 16, 20, 21, 22, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 38, 39, 41, 43, 50 and 51.

V

Cause was established to discipline respondent's license pursuant to Business and Professions Code section 2227 for violation of section 2262, creating a false medical record with fraudulent intent, by reason of Findings 10, 11, 12, 14, 16, 20, 21, 22, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 38, 41, 42, 43, 50, and 51.

VI

Cause was established to discipline respondent's license pursuant to Business and Professions Code section 2227 for violation of section 2264, employing unlicensed persons to engage in the practice of medicine, by reason of Findings 13, 20, 21, 24, 32, 45, 46, 47 and 51.

VII

Cause was not established to discipline respondent's license pursuant to Business and Professions Code section 2227 for violation of section 2306, practicing medicine while his license is suspended, by reason of Findings 1 and 19.

VIII

Cause was not established to discipline respondent's license pursuant to Business and Professions Code section 2227 for violation of section 725, repeated acts of clearly excessive prescribing of treatment, by reason of Finding 52.

ORDER

Physician's and Surgeon's Certificate No. G38603 issued to Jeffrey Jay Rutgard is revoked.

Dated: May 18, 1994

JOYCE A. WHARTON
Administrative Law Judge
Office of Administrative Hearings