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

In the Matter of the Accusation Against:

V. GEORGES HUFNAGEL, M.D.
Certificate No. G-035472

Respondent.

No. L-39699

NOTICE OF NON-ADOPTION OF PROPOSED DECISION

NOTICE TO ALL PARTIES:

YOU ARE HEREBY NOTIFIED that the Division of Medical Quality voted not to adopt the proposed decision recommended in this case. The Division itself will now decide the case upon the record, including the transcript.

To order a copy of the transcript, please contact the Transcript Clerk, Office of Administrative Hearings, 314 West First Street, Los Angeles, CA 90012.

After the transcript has been prepared, the Division will send you notice of the deadline date to file your written argument. Your right to argue on any matter is not limited. The Division is particularly interested in arguments on the following:

Why the penalty should not be increased.

In addition to written argument, oral argument may 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 of hearing.

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:

Division of Medical Quality
BMQA
1430 Howe Avenue
Sacramento, CA 95825
(916) 920-6363

Dated: March 6, 1989

DIVISION OF MEDICAL QUALITY
BOARD OF MEDICAL QUALITY ASSURANCE

By Vernon A. Leeper

VERNON A. LEEPER, Chief - Enforcement

FL:klb 12/86

BEFORE THE
DIVISION OF MEDICAL QUALITY
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STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
V. GEORGES HUFNAGEL, M.D. 8635 West Third Street Los Angeles, California 90048	)	NO. D-3613
Physician and Surgeon's Certificate No. G 035472,	)	L-39699
Respondent.	)	

PROPOSED DECISION

This matter came on regularly for hearing before Robert A. Neher, Admnistrative Law Judge of the Office of Administrative Hearings, at Los Angeles, California on November 16, 17, 23, 24, 25 and 30 and December 1, 2, 3, 4, 7, 8, 9, 10, 11, 14, 15 and 18, 1987, and thereafter on June 13, 14, 15, 21, 22, 23, 24 and July 6, 1988 at various hours. Antonio J. Merino, Deputy Attorney General, represented the complainant. Respondent appeared in person and was represented by Robert H. Gans, Attorney at Law. Documentary and oral evidence and evidence by way of stipulation was introduced, and the record left open for the parties to file written briefs. On August 4, 1988, complainant's opening brief was received and marked as Exhibit 83, for identification only. On August 31, 1988, respondent's post-hearing brief was received and marked as Exhibit V, for identification only. On September 9, 1988, complainant's reply brief was received and marked as Exhibit 84, for identification only. On October 20, 1988, oral argument was heard, and thereafter the matter was submitted. The Administrative Law Judge finds the following facts:

I

Kenneth J. Wagstaff made the Accusation in his official capacity as the Executive Director of the Board of Medical Quality Assurance.

II

On or about September 6, 1977, the Board issued to respondent V. Georges Hufnagel, M.D. physician's and surgeon's certificate number G-035472. Said certificate is now, and was at all times mentioned herein, in full force and effect.

III

On or about March 8, 1985, Marsha C., a thirty-four year old female patient, was treated by a physician other than the respondent, and underwent a suction curettage for an incomplete abortion. That attending physician suspected a septate or bicornuate tissue. On or about March 12, 1985, the patient experienced passage of a fetus. The patient was instructed to await spontaneous passage of possible remaining tissues and to call the physician if bleeding became heavy or if she developed a temperature.

On or about March 15, 1985, the patient, who was afebrile, consulted with respondent who diagnosed post-operative complications with a possible perforation. Respondent admitted the patient to Beverly Hills Medical Center in Los Angeles for a repeat D & C under laparoscopic observation and surgical repair of necrotic cervical laceration.

On or about March 15, 1985 respondent performed surgery and reported evidence of a previous uterine perforation with slow oozing of blood and 30-40 cc's of blood in the peritoneal cavity. Respondent also noted omental bleeders. Respondent stated in the operation record that fetal tissue was present in the abdomen.

IV

It was not established that respondent's attempt to suture the laceration and perforation on this asymptomatic post-abortal patient seven days after the previous procedure constitutes gross negligence or incompetence. Rather it appears to be a judgment upon which reasonable physicians could disagree.

V

Respondent attempted to perform a suction curretage on this patient which she failed to report in the records. It was not established that her failure to report said incomplete procedure constitutes gross negligence. As to this patient, the evidence failed to establish whether the prior physician or respondent was responsible for initially puncturing the uterus.

Respondent recorded in the operation record that, after opening the abdomen, she passed a cannula through the cervix, then through the uterine perforation, and that repair followed. In fact, respondent did not pass a probe through until after she completed the repair, and then proceeded to repair her repair with further stitches. It was not established that said misstatement on the operation record constitute gross negligence.

VI

Respondent recorded in the operation record that fetal tissue was present in the abdomen. In fact there was no fetal tissue. There was decidua present, which was abnormal; however, her reporting it as "fetal" tissue was not established as constituting incompetence.

VII

It was not established that respondent's performance of a uterine suspension on this patient in the face of uterine inflammation constitutes gross negligence or incompetence.

VIII

Approximately in March 1985, respondent caused billings to be submitted for her treatment of Marsha C., hereinabove set forth, for a total of $12,600. Said billings constitute acts of dishonesty or corruption, in that she billed for procedures and treatment which she did not perform including, enterotomy/large bowel, suture of intestine, biopsy of the ovary, and trachelorrhaphy. Also, she billed at the full rather than a percentage rate for each of the multiple procedures; and separately for incidental examinations, procedures and visits which constitute part of the surgery.

IX

The conduct set forth in Finding VIII constitutes the respondent knowingly making and signing documents related to the practice of medicine which falsely represented the existence or nonexistence of a state of facts; as well as creating false medical records with fraudulent intent.

X

On or about March 18, 1985, Jolin C., a 32 year-old female, was admitted to Beverly Hills Medical Center in Los Angeles, California, by another physician, for evaluation of abdominal pain with vomiting.

On or about March 21, 1985, respondent performed a laparoscopy and liver biopsy. Said procedure revealed relatively limited intrapelvic adhesions and bilateral hydrosalpinx. The liver biopsy disclosed normal results. The D & C and hysteroscopy scheduled for the same time were crossed out on the records. The hysteroscopy was apparently not performed due to hospital equipment problems.

On or about March 22, 1985, respondent performed a hysteroscopy, dilation of cervix, curettage of uterus, video, cervical laser, and urethral dilation. The stated bases for these procedures were cervical dysplasia, pelvic pain and pelvic mass on ultrasound.

XI

It was not established that respondent failed to obtain consent for laser of the cervix, said consent was merely not obtained until after the first surgery, due to nursing error.

XII

It was not established that the performance of the second surgery by respondent on March 22, 1985, constitutes gross negligence or incompetence.

There was no indication from the anesthesiologist, who worked both operations, that the patient was at unreasonable risk on the second day.

XIII

Respondent reported and billed for the two surgical procedures as occurring on March 22, 1985, rather than on March 21 and 22, 1985. Respondent reported that the liver biopsy was performed on March 22, 1985, rather than on March 21, 1985. Said erroneous entries are found to be typographical errors and not gross negligence.

Respondent did not perform the D & C and hysteroscopy on March 21, 1985, and failed to indicate in the operation record why these procedures were not performed on that date and why she subjected the patient to surgery on the following day. Though this constitutes poor charting and documentation practice it is not gross negligence.

XV

Approximately in April 1985, respondent caused three billings to be submitted for her treatment of Jolina C., hereinabove set forth in the amount of $15,145. Said billings constitute acts of dishonesty or corruption in that respondent twice billed for the D & C; twice billed for comprehensive history when only one was done and that by another doctor; billed for a bowel exploration, which is hereby found not to have been performed; and billed for a liver biopsy that was performed by another. Also, she billed individually for incidental acts which were part of the major procedure, such as exam under anesthesia, irrigation, fulguration, aspiration, cervical medications, etc.

XVI

The conduct set forth in Finding XV constitutes the respondent knowingly making and signing documents related to the practice of medicine which falsely represented the existence or nonexistence of a state of facts; as well as creating false medical records with fraudulent intent.

XVII

On or about January 7, 1985, Rama H., a forty-four year old female patient, consulted with respondent at her office in Los Angeles for a second opinion. The patient had been previously advised as to her condition, and the options of undergoing a hysterectomy or a myomectomy were explained by another physician who had followed her since 1982 and documented a leiomyomata uteri. The patient and doctor scheduled for a total hysterectomy. There is no evidence that this was not a free and voluntary agreement on the part of Rama H.

On the other hand, the evidence is clear that respondent, immediately upon a phone call from Rama H. told her she didn't need a hysterectomy; and thereafter did a selling job on Rama H. and rather than offering a choice, as she asserts, painted a glorious picture of "her techniques" and successes, and carried her campaign against hysterectomies directly to this patient to the extent that the patient was never really offered a choice of treatment but

rather sold her on a myomectomy, which is found to be the only operation that respondent would ever have performed on this patient.

The patient signed a consent, albeit not an informed one, to a myomectomy, canceled the hysterectomy with her previous physician, and on January 22, 1985 was admitted to the Beverly Hills Medical Center for myomectomy and incidental appendectomy, with a preoperative diagnosis of menometrorrhagia and pelvic pain.

Respondent referred the patient for a consultation on January 23, 1985, with E. Austin, M.D., who described symptoms of severe heavy bleeding, anemia, dysmenorrhea, pelvic pain, and inability to have coitus due to pain.

On or about January 23, 1985, respondent performed an exploratory laparotomy, myomectomy, lysis of adhesions, right ovarian cystectomy, multiple uterine biopsies, and uterine reconstruction. The surgery disclosed a large (7 x 6 x 5 cm) leiomyomata uteri, adenomyosis and endometriosis of the right ovary. The patient was discharged on January 27, 1985.

The post surgical findings and patient's condition after surgery continued to disclose the need for a hysterectomy. Respondent ignored the clear facts, and again refused to indicate to the patient a need for hysterectomy.

Postopertively, the patient experienced persistent menometrorrhagia, unresponsive to respondent's treatment by several hormonal regimens. On or about July 15, 1985, another physician performed a hysterectomy for adenomyosis and leiomyomata with persistent menometrorrhagia. The uterus which was removed was 285 gm., and 12.4 x 6.5 x 6.2 cm. with extensive adenomyosis.

Thereafter, respondent many months after the patient had left her care, souped up a "Progress Note" riddled with untruths and warped facts and added the note to the patient's records.

The conduct of respondent in her care and treatment of Rama H. constituted gross negligence in failing and refusing to perform a hysterectomy, refusing and failing to even give the patient a clear option as to treatment choice, refusing to disclose the need for further surgery, and ignoring the condition of the patient in favor of respondent's pre-conceived notions, right or wrong, of the general condition of obstetrics and gynecology in the medical community.

XVIII

Approximately in May 1985, respondent caused billings to be submitted for her treatment of Rama H. in the amount of $10,550. Respondent's billings for her treatment of Rama H., hereinabove set forth, constitute acts of dishonesty or corruption in that she billed separately for the myomectomy and an hysterorrhaphy (which is part of the major procedure); billed for an enterotomy and endometrial biopsy, which were not performed; and billed for extended hospital visits, which were brief.

XIX

The conduct set forth in Finding XVIII constitutes the respondent knowingly making and signing documents related to the practice of medicine which falsely represented the existence or nonexistence of a state of facts; as well as creating false medical records with fraudulent intent.

XX

On or about April 24, 1985, Jan L., a 33 year old female, seeking a new gynecologist, consulted with respondent at her office in Los Angeles for a check-up. The patient did not complain of any symptoms, other than a feeling of swelling and occasional discomfort in her right side.

Respondent examined the patient bimanually and reported her findings to be anterior tumors of the uterus. An ultra sound was performed at Tower Radiology which appeared to show a possible fibroid tumor. Respondent proposed surgery to remove the "fibroid".

Respondent's office records refer to a "pre-op: laparoscopy to make sure." Respondent, through her office staff, proposed the following surgical procedures to the patient's insurance carrier: hysteroscopy, D & C diagnostic, exploratory laparotomy, myomectomy, uterine suspension, salpingoplasty, appendectomy, laser, lysis of adhesions, and uterine reconstruction; in short, a panoply of her female reconstructive surgery regimen.

Respondent made a pre-op appointment with the patient. The patient sought a second opinion. The second physician referred her to an internist for a blood test and had another ultrasound performed, which conflicted with the one performed at Tower.

Jan L. spoke to respondent, and because of the conflicting information canceled her pre-op appointment.

The second physician, due to the conflicting ultrasound performed a D & C on June 25, 1985, which showed no indication of a degenerating myoma.

On June 27, 1985, respondent sent Jan L. a letter (Exhibit 10) which discussed her "fibroid tumors" and recommending "direct evaluation" to "avoid a hysterectomy". Under the facts of this case, that letter can only be described as an instrument of terror, contemplated by respondent to coerce the patient into returning for several procedures which respondent had every reason to believe were unnecessary. Respondent's assertion that she meant that letter as a "cover your ass" letter is found to be untrue. She did in fact send such a letter (Exhibit 11.) on August 9, 1985, withdrawing as Jan L.'s physician.

XXI

The conduct of respondent regarding Jan L. clearly evidences incompetence on the part of respondent discharging her duties as a physician and surgeon, in recommending unnecessary surgeries and in sending that alarming terror letter to the patient.

XXII

The fact that a third physician, two years later found and removed a fibroid from the patient neither excuses nor mitigates respondent's conduct. No evidence was introduced tending to show the fibroid was there in 1985, or that the patient ever had a degenerating fibroid or adenomyoma while a patient of respondent.

XXIII

The fact that a malpractice negligence case filed by the patient against respondent was dismissed does not work a collateral estoppel in this case. The complainant was neither a party nor privy to a party therein, nor were the issues the same as herein, nor does it bear on the issue of incompetence.

XXIV

Approximately in October 1985, Christine S., a 38 year old female patient, consulted with respondent at her office in Los Angeles with complaints of menses every 17 days, with increased bleeding and pain and tenderness of breasts. Respondent examined the patient and felt a pelvic mass; an inconclusive ultrasound was done. Approximately in December 1985, a CT scan of the pelvis was performed,

which showed a mass. The patient was placed on Anaprox with partial relief and birth control pills for five weeks during which time she had no menses.

On or about February 13, 1986, respondent admitted the patient to the Beverly Hills Medical Center in Los Angeles with an admitting diagnosis of pelvic pain and pelvic mass. Respondent ordered the following laboratory tests: testosterone - free and total; androsterone, LH, sex binding hormone, progesterone, DHEA, FSH, Estrogen, Prolactin, DHEAS, CMV Titer, Chlamydia Titer, GC by CF, EBV Titer, Mycoplasma Titer, Thyroid Panel/TSH.

On or about February 13, 1986, respondent performed a diagnostic laparoscopy, followed by a laparotomy. At the laparoscopy, respondent noted posterior uterine irregularity, normal tubes and a few bilateral adhesions. At the laparotomy respondent apparently thought she was dealing with a tumor and made a large cut in the uterus. A biopsy was performed with findings of adenomyosis. Respondent repaired the uterus and did a uterine suspension and described that additional tissue was wedged out from the uterus. Respondent also reported that she performed lysis of adhesions. Postoperatively respondent placed the patient on Danazol for six months to one year. The patient was discharged on February 17, 1986. A month after the operation, the patient continued to have pain, particularly at the incision site. Respondent treated that incisional site locally, with some relief.

On or about June 27, 1986, respondent again admitted the patient to the Beverly Hills Medical Center for evaluation of chronic right-side external pain confined to abdominal wall only. On that day, respondent performed a diagnostic laparascopy and incisional repair with suture, and granuloma removal. Respondent noted on the operation record that omental fat was found and partially excised from the posterior uterine surface. Respondent also performed an exploration of the incision site and found a granuloma which was excised. Respondent also performed excision of adhesions.

On or about June 28, 1986, respondent discharged the patient. Respondent noted no physiological reasons for the patient's major complaints of pain. After the discharge, the patient continued to experience pain.

XXV

It was not established that respondent's conduct during the surgical procedure of February 13, 1986, constitutes gross negligence in progressing to a laparotomy upon the laparoscopic findings that she had, even though they were not conclusive.

XXVI

It was not established that the size of the incision made in the attempted myomectomy constituted gross negligence; or that respondent, after hearing the true diagnosis of adnomyosis leiomyas and wedging out further uterine tissue, was guilty of gross negligence. The evidence is unclear as to whether or not respondent ignored the pathology result, or was trying to remove as much of the adenomyosis as possible, or as she claims, taking tissue necessary to make a better closure and re-approximate a normal uterus. The burden being on complainant to establish that fact, gross negligence is not found.

XXVII

It was not established that respondent was negligent in using stitches to shorten the round ligament in performing the uterine suspension. Said procedure appears to be one of several acceptable methods used by the medical community.

XXVIII

Respondent's conduct during the second surgical procedure on June 27, 1986, in excising ugly fatty adhesions from the posterior fundus for cosmetic purposes was not appropriate, would further increase the patient's risk of more adhesions, and constitutes incompetence.

Respondent's assertion that by saying "very ugly appearance" she meant "bad"; and that her reporting that it "was just an uncosmetic appearance", was an error by the transcriber; is found to be untrue and a recently concocted alibi.

XXIX

It was established that the multitude of laboratory tests ordered by respondent upon admitting the patient to the hospital on February 12, 1986, constitutes repeated acts of clearly excessive use of diagnostic procedures.

Under the facts of this case, respondent's assertion that the patient was an "infertility patient" is disbelieved. The 38 year old patient expresssed no interest in becoming pregnant, expresssed no present desire for children in the future, and sought out respondent for relief of pelvic pain, none of which facts justify any of the hormone tests, titers, or other panels. The fact that the patient agreed to a laparoscopy or even a laparotomy and uterine suspension does not make her an "infertility" patient

no matter how much respondent might wish that she were. It is obvious that the respondent ordered the tests for her own benefit, which was a monetary one.

XXX

On or about June 13, 1984, respondent examined Joan T., a forty-two year old female patient on a consultation referred from another physician. The patient had a history of off and on low grade fevers followed by a sudden onset of severe lower left quadrant pain and fever of 101°. The patient had been treated with antibiotics and improved but after she was sent home and off antibiotics she experienced moderate discomfort and low grade fevers. The patient gave a history of a prior laparascopy and cystectomy in 1980. Respondent noted the patient had anxiety over her failure to achieve pregnancy.

On or about June 13, 1984, the patient was admitted to Century City Hospital in Los Angeles. On or about June 14, 1984, respondent performed a dilation and curettage, hysterescopy, and diagnostic laparoscopy. The preoperative diagnosis was acute and chronic pelvic pain, acute salpingitis, failed to defervesce completely on I.V. and p.o. antibiotics, and history of infertility, inability for patient to conceive pregnancy.

The laparoscopy revealed severe adhesions and blockage of both fallopian tubes. Respondent stated on the operation record that fibroids of undetermined size were present on the anterior and posterior fundus. Respondent also noted during the course of the hysteroscopy that fibroid tumors impinged on the flow of the dye.

Respondent made a postoperative diagnosis of severe pelvic adhesions, bilateral tubal blockage, multiple myomas, adhesions to the intestines on the left side, tying up the large bowel, adhesions on right side ovary with multiple follicular cysts. Respondent recommended further surgery for the release of the adhesions and myomectomy to relieve pain and to increase probability of fertility. The patient was discharged on June 17, 1984.

XXXI

On or about July 4, 1984, respondent again admitted the patient to Century City Hospital with a history of severe chronic pelvic pain and diagnosis of severe adhesions, endometriosis and uterine fibroid. On or about July 5, 1984, respondent performed an exploratory laparotomy, lysis of adhesions, left and right ovarian cystectomy, ovarian ligament suspension, uterine suspensions, lysis of adhesions, electrofulguration of endometriosis, myomectomy and irrigation.

Respondent described the procedure in the operation record of July 5, 1984, including that the ovaries were fixated to their ligaments with prolene and that the uterine areas felt firm where respondent suspected fibroids. Respondent then made incisions on the uterus and removed a small, hard, firm myomata on one side but failed to find any fibroid on the other. She sent the tissue to the pathologist for a biopsy because she suspected adenomyoisis. Respondent discharged the patient on July 11, 1984.

XXXII

It was not established that respondent's conduct in her treatment of Joan T. constituted gross negligence by her failure to perform hysterosalpingography to demonstrate whether fibroids actually obstructed the tubes. Respondent did a hydro-tubation with indigo carmine, and it was not established that such procedure was not sufficient to determine the obstruction.

Further, it was not established that hydro-tubation was not a sufficient procedure to use as a check for tubal patency.

XXXIII

It was not established that respondent's conduct during the second surgery in July 1984 constituted gross negligence, or even ordinary negligence, in that she fixated the ovaries to their ligament and used a thin permanent suture (prolene).

Though any permanent suture could cause chronic pain, it also may not; and there was no substantial evidence that respondent failed to weigh the potential risks against potential benefits in this case; or that the fixation itself was a departure from the standard of care.

XXXIV

It was not established that there was no basis for removing the uterine fibroids by myomectomy, or that the incision made by respondent to do so was without the standard of practice with this infertility patient. Though she may have made an extra cut and came up empty.

XXXV

On or about April 2, 1985, respondent admitted Marsha W., a 36 year old female patient, Gravida 3, para O, with two miscarriages and one abortion, to the Beverly Hills Medical Center in Los Angeles. The patient had previously on February 12, 1985, undergone a diagnostic laproscopy by another physician, who had noted adhesions

involving the right ovary, left tubo-ovarian adhesions and adhesion around the left utero-sacral ligament. This physician noted that the bladder area and cul-de-sac were otherwise free of pathology, including endometriosis. The physician found one 3 cm. anterior fibroid which did not involve the uterine cavity and recommended a laparotomy with lysis of adhesions and myomectomy. At her insurance company's request the patient sought out respondent for a second opinion.

On or about April 3, 1985, respondent listed that she performed, among other procedures, an exploratory laparotomy, cyst aspiration bilaterally on ovaries, left ovarian cystecotmy, right and left ovarian transfixation, multiple myomectomy, complex, hysteroplasty, salpingolysis, bilateral salpingoplasty, uterine suspension, round ligament transfixion, round ligament hypoplexy, tubolysis, adnexal adhesion, ovarian lysis, and abdominal pelvic adhesion lysis.

In the operation record, respondent described the uterus as pulled into the cul-de-sac, dense adhesions between the uterus and bladder, much cul-de-sac endometrosis, and bilateral salpingoplasties. Respondent transfixed the ovaries with Tevdek, a permanent suture, to the posterior aspect of the uterus with 2-0 Tevdek and stated she performed myomectomies on the anterior fibroid and on three additional fibroids described as minute. The pathology report describes two fibroids, one 3 cm. and the other 1 cm.

Respondent made a diagnosis of fibroid tumors and possible adenomyosis with significant endometriosis. Respondent discharged the patient on or about April 6, 1985. Thereafter the patient consulted with another physician and approximately in January 1986, the patient underwent a laparoscopy.

XXXVI

It was not established that respondent's conduct in performing the myomectomies on April 3, 1985, constituted negligence because of the small size of some of the fibroids or because of their location.

Once inside this patient, it would appear to be up to the physician's judgment as to which, if any, fibroids should be revmoved. In removing the minute fibroids, respondent apparently weighed the probability of patient discomfort from the probable adhesions against the risk of possible rapid growth of the fibroids which might occur and complicate a future pregnancy.

XXXVII

It was not established that respondent's conduct in using a permanent suture, such as Tevdek, to sew the ovaries to the back of the uterus constituted gross negligence, or that respondent's conduct in using Tevdek to transfix the round ligaments constituted incompetence.

There was no substantial evidence that the procedures should not have been performed; and the evidence would indicate that if dissolvable sutures were used, the suspension might give way and cause the uterus to drop back into the cul-de-sac.

XXXVIII

Approximately in April 1985, respondent caused billings to be submitted for her treatment of Marsha W., hereinabove set forth at paragraph 24, in which she billed $21,175.00 for the surgery. Said billing constitutes acts of dishonesty or corruption in that she billed for procedures not performed, such as, ventral hernia repair and laparoscopy, in that she charged twice for a bilateral salpingoplasty when one was done, billed for procedures which should have been included in the surgical fee, and billed for independent multiple procedures at the full rate rather than on a percentage basis.

In this case the round ligament repair neither described nor constituted a ventral hernia repair; and respondent's assertion variously of "clerical error" or "computer error" are found to be untrue.

Further, respondent on the insurance billing listed endometriosis and adenomyosis as two of the diagnoses at a time when she knew or had every reason to know that that was untrue.

XXXIX

On or about March 26, 1985, Karen G., a 33 year old female patient, consulted with respondent at her office in Los Angeles with a complaint of severe pelvic pain. A sonogram had been previously done by another physician. Respondent performed a pelvic ultrasound in her office and indicated a possible right ovarian dermoid measuring 4.1 cm.

On or about March 27, 1985, respondent admitted the patient to the Beverly Hills Medical Center in Los Angeles. On that date, the patient was examined by a consulting physician who noted a pulse of 44. On or about March 28, 1985 respondent scheduled a diagnostic laparoscopy. Preoperatively the patient's pulse was recorded at 60. During the infusion

of carbon dioxide during the laparoscopy, respondent noted severe bradycardia. The respondent responded with an immediate open laproscopy and noted non-clotting omental blood, followed by an immediate laparotomy to rule out major vessel or bowel injury. The laparotomy revealed no evidence of bowel or vessel injury. Respondent performed an excision of a small 1.5 cm. right ovarian dermoid, lysis of small adhesions on the ovaries and several fibrous adhesions on the back of the uterus, a uterine suspension and wedge resection of the opposite ovary and incidental appendectomy. The patient was discharged on April 3, 1985, with a principal diagnosis of benign neoplasm ovary.

XL

It was not established that respondent was negligent by failing to recognize this patient's preoperative bradycardia, as reflected by pre-op pulse rates of 44 and 60. The only real issue regarding this patient is whether or not respondent was negligent due to over-reacting to the patient's bradycardia, and performing a laparatomy.

Though severe bradycardia, under 40, was noted and respondent performed an open laparascopy; the record indicates that she probably proceeded to perform the laparatomy as much by reason of viewing non-clotting blood through the laparascope, as due to the bradycardia. The evidence was not clear and convincing that her action constituted a deviation from the standard of care under all the facts.

XLI

It was not established that respondent was dishonest in her billing relative to Karen G.

XLII

On or about March 27, 1985, Deborah S., a 42 year old female patient, consulted with respondent at her office in Los Angeles. Thereafter a biopsy of the vulval area disclosed Bowen's disease, focal vulvar carcinoma in situ, extending to the margins. Respondent also noted hermorrhoids.

On or about April 17, 1985, respondent admitted the patient to the Bevery Hills Medical Center with an admitting diagnosis of internal hemorrhoids and Bowen's disease for excision. On or about April 18, 1985, respondent noted in the operation record that she performed the following surgical procedures: wide excision of invasive tumors, dying of tumors, D & C, cervical biopsy, hysteroscopy, excision of perineum, hemorrhoidectomy, plastic repair, perineoplasty, hymenoplasty, and labioplasty. Pathology confirmed vulvar carcinoma in situ. Respondent discharged the patient on April 26, 1985.

XLIII

Respondent's conduct in her treatment of Deborah S. constituted negligence in that the D & C, cervical biopsy and hysteroscopy were not indicated. Respondent's assertion that she performed those procedures due to a possible "field effect" of the Bowen's disease, or because it is a multi-focal disease is found to be a recent concoction. In her post-op records she indicated she was searching for other possible types of carcinoma. It is clear that she, at best, had a patient history of a 20-year old cervical conization (without getting or seeing the report) and a patient history of a 5 year old "bad pap smear" (with a March 17, 1985 normal pap smear) neither of which she could reasonably rely on as a medical indication for the procedures.

Further, her assertion that she was only carrying out the orders of the pathologist is found to be untrue. Rather the facts are that she made a wide incision in the vulvar carcinoma and had it analyzed to determine whether to proceed with the scheduled hermorrhoidectomy.

XLIV

Approximately in April and May 1985, respondent caused billings to be submitted for her treatment of Deborah S. for $10,595. Said billings constitute acts of dishonesty or corruption in that she billed separately for procedure and treatment which should have been included under the principal procedure and in that she indicated she performed and billed for treatment and procedures which were not performed, such as, hymenectomy, plastic revision of hymen, and plastic repair of introitus. Further, she billed for treatment and procedures performed by another physician, to wit: the anal sphincteroplasty and the hemorrhoidectomy.

XLV

On or about October 9, 1985, Alicia G., a 25 year old female patient, consulted with respondent for severe pelvic pain at her office in Los Angeles. On that same date, respondent admitted the patient to the Beverly Hills Medical Center in Los Angeles with an admitting diagnosis of acute salpingitis for intravenous antibiotic therapy.

The patient exhibited pelvic tenderness but was afebrile, with a normal complete blood count and sed rate. A pelvic ultrasound, done at the hospital by staff, disclosed changes suggestive of inflammation. Respondent considered pelvic inflammatory disease and toxic shock syndrome. The patient sought other medical opinions and discharged herself on October 11, 1985.

XLVI

It was not established that respondent failed to consider any other differential diagnoses such as Mittleschnertz, occult pregnancy, or ectopic pregnancy; or failed to order a serum pregnancy test.

XLVII

On or about October 18, 1985, respondent caused billing to be submitted for her treatment of Alicia G. Said billings constitute acts of dishonesty or corruption in that she indicated she performed and billed for services which she did not perform, such as, complex initial consultation, extended hospital visit and comprehensive consultation. Respondent's assertion that she saw the patient in the hospital on the night of October 9th is found to be untrue. She only saw the patient twice, once in her office for the initial visit and once in the hospital on the night of October 10, 1985.

XLVIII

The hospitalization of Alicia G. constituted excessive hospitalization on the part of respondent, in that though the patient had pelvic pain she had no other documented symptoms which demanded hospitalization.

Though she now denies it, respondent on October 9th told both the patient and the patient's father that the patient had toxic shock syndrome. The admitting record indicates a diagnosis of acute salpingitis. On the night of October 10, 1985, respondent apparently had a disagreement with the patient's family and other doctors including the patient's father who is also a doctor over the necessity of hospitalization and proposed treatment (which apparently included a proposed laparoscopy and tubal lavage).

Thereafter on October 11, 1985, respondent created a physician's note in an obvious attempt to fraudulently justify what she then must have realized to have been an unjustified hospitalization. Four months later, she wrote a "progress" note, still attempting to cover up.

In those notes, respondent falsely represented the patient's condition and respondent's knowledge of that condition as of October 9, 1985, the date of the presenting complaint and hospitalization.

XLIX

On or about February 20, 1985, Florence C., a 51 year old female patient, consulted with respondent at her office in Los Angeles for a routine gynecological examination. Respondent informed the patient that she should have a D & C along with surgical removal of light tissue on the lip of the vagina and a biopsy of tissue near the cervix.

On or about March 4, 1985, respondent admitted the patient to the Beverly Hills Medical Center in Los Angeles with an admitting diagnosis of dysfunctional uterine bleeding and vaginal lesion. Respondent operated on that date and removed two small lesions; neither of which required a wide excision. The pathology report revealed no evidence of malignancy. Respondent discharged the patient on that same date.

L

Approximately in April 1985, respondent caused billings to be submitted for her treatment of Florence C. for $2450. Said billings constitute acts of dishonesty or corruption in that she billed for plastic repair of labia which was not done, and billed separately for procedures which should have been included under the billing for the D & C, or should have been billed at a lesser rate as secondary to the principal procedure; to wit: exam under anesthesia, endocervical curettage, cervical medication, cultures, and comprehensive history.

LI

On or about July 14, 1985, respondent admitted Isabell M., a 32 year old female patient, into the Beverly Hills Medical Center in Los Angeles, with an admitting diagnosis of pelvic mass.

On or about July 15, 1985, respondent performed a surgery. In the operation record, respondent indicated she performed, among other things, complete female reconstructive surgery, an exploratory laparotomy, appendectomy, exploration of the bowel, ovarian cystectomy, abdominal pelvic lysis, adnexal adhesion lysis and tubolysis, uterine suspension, fulgaration of ovarian and peritoneal tissues, hysteroplasty, complex myomectomy, salpingolysis, fimbrioplasty, hydrotubation and salpingoplasty bilaterally. The patient was discharged on July 21, 1985.

LII

Thereafter, respondent caused to be submitted a billing for her services in which she indicated diagnoses of pelvic pain, pelvic adhesions, uterine prolapse, menometrorrhagia, myomata uterus, pelvic adhesions and dysmenorrhea. Respondent billed a total of $15,950 for her treatment of this patient during the hospitalization, including $5200 for pelvic reconstructive, $6000 for abdominal reconstructive, $1200 for appendectomy and $2500 for myomectomy. Respondent also billed for an extended hospital visit and for a comprehensive hospital examination.

Respondent's billing constitutes acts of dishonesty or corruption in that she billed more than once for the same procedures, (three extended visits when one was done) and (pelvic reconstructive as well as abdominal reconstructive) billed separately for procedures and treatment which should have been included under the principal procedure (such as the myomectomy) and billed for procedures performed by another (the appendectomy).

LIII

The conduct set forth in Finding LII constitutes knowingly making and signing documents related to the practice of medicine which falsely represented the existence or nonexistence of a state of facts; as well as creating false medical records with fraudulent intent.

The fact that the insurance carrier disallowed the bill and that respondent sent in a handwritten bill on or about May 22, 1986 for $7,800 for "female reconstructive surgery", neither excuses nor mitigates the conduct. Respondent's assertion that they generated the original bill, but didn't send it, and never sent a bill until May 22, 1986 is found to be untrue.

LIV

On or about April 9, 1986, Debra Sa. a 36 year old female patient, consulted with respondent at her office in Los Angeles with a complaint of bleeding from her vagina for a period of 15 days.

On or about April 12, 1986, respondent admitted the patient to the Beverly Hills Medical Center with an admitting diagnosis of dysfunctional uterine bleeding for a diagnostic laparoscopy to confirm abnormalities found on the examination, to rule out signs of endometrial carcinoma from the uterus, and for D & C, hysteroscopy, and laparoscopy.

On or about April 12, 1986, respondent performed a D & C, a hysteroscopy and a diagnostic laparoscopy. Respondent noted in the operation record several peritubal cysts on the fallopian tubes. Respondent discharged the patient on that same date and recommend major surgery to reconstruct the abnormalities she noted.

LV

On or about April 14, 1986, the patient signed a consent form for respondent to perform, among other things, tuboplasty and lysis of adhesions. The patient thereafter canceled the surgery and went to another physician.

Said consent form of April 14, 1986, constitutes an act of dishonesty or corruption by respondent in that the patient did not require tuboplasty or lysis of adhesions, nor was it reasonably probable that she would in the near future.

Respondent's assertions, variously, that she was merely "over consenting" or didn't intend to perform all of the procedures she got consents for is found to be untrue.

Rather it is found that said form constituted step one in respondent's plan to try to sell the patient on having the operation performed to save her fertility.

LVI

The surgical consent form presupposes respondent's finding of a need for the surgery and her commendation that it be done; and constitutes the knowing making of a document related to the practice of medicine which falsely represents the existence of a state of facts, on her part.

LVII

The respondent's conduct set forth in Findings VIII, IX, XV, XVIII, XXXVIII, XLII, XLIV, L, and LII, and each of them constitutes knowingly presenting or causing to be presented false or fraudulent claims for the payment of a loss under a contract of insurance, or knowingly preparing, making, or subscribing writings with intent to present or use them or allow them to be presented or used in support of such claims.

LVIII

Respondent's testimony in this case not only lacked credibility, it lacked candor. She was thoroughly impeached by other witnesses, written records, prior inconsistent statements, conflicting answers to the same questions, and

outright lack of forthrightness. She was at various times evasive, furtive, non-responsive, and showed an extremely selective memory.

LIX

Respondent's assertion of a lack of knowledge, input, and fraudulent intent in the creation and submission of the false billings and medical records hereinabove found to have occurred is disbelieved. Rather, it is clear that just prior to January 1, 1985, in conjunction with her husband (then boy friend) a plan was conceived to maximize the income to her practice by submitting claims or bills to insurance carriers in a maximum amount for each and every conceivable procedure which could have occurred during a surgery, whether incidental or not, performed by her or another, included or not, and indeed in many instances performed or not.

She gave her husband, an attorney, a facsimile signature, authority to use it, and essentially a blank check to allow him to try; initially to stick the carrier; and then if the carrier paid only a part of her claim, to bill the patient the excess; and if the patient complained, to write it off in most cases.

Respondent's attempt to distance herself from the billing and financial part of the practice was unsuccessful, not only did she know about and intend such bills and claims, but she knew that the claims were being prepared from her notes and records which she also knew contained false or misleading entries.

Her claims that the false records, bills, and claims were the result variously of her husband's mistakes, clerical errors, computer errors, transcriber's errors, or staff mistakes were not established, and are found to be spurious.

LX

As to the testimony of the expert witnesses, the testimony and opinions of Dr. Quevedo was the least credible evidence of all the experts. The testimony and opinions of Dr. Hummer, who is well credentialled and credible, was very valuable in most instances; however, in the Findings hereinabove found to be true, other evidence was more convincing; and in some instances, hypothetical facts upon which certain opinions were based were either not established or were rebutted.

The testimony of Dr. Parks was somewhat impeached on a collateral matter and his opinions were subjected to a skeptical review.

The testimony of Dr. Austin was also viewed with skepticism by reason of his involvement in so many of the operations in those matters; as was similarly the testimony of Dr. Rubenstein.

Respondent's attempt to discredit Drs. Mason and Gersh for bias and/or lack of knowledge of community standards, regarding their opinion as to her conduct herein, failed.

LXI

The fact that respondent shows no remorse, little understanding of the effects of her conduct (except as to herself) and denies all knowledge of wrongdoing is not remarkable under the facts of this case.

She presents herself to patients, colleagues and this Board as an innovator, a developer of new procedures, and a crusader on the cutting edge of OB/GYN and fertility surgery, who uses micro-surgery, unique irrigation solutions, innovative ultrasound techniques, and possesses special knowledge; none of which was established by substantial competent evidence. Rather, she appears to be an expert of her own creation, much like the entertainer or politician who begins to believe the truth of his own press releases because they appear in a newspaper; or the person who starts a rumor and then accepts it as proven fact, when he hears it back from someone else.

LXII

Respondent is one of many medical professionals who believe that too many unnecessary hysterectomies are being or have been performed; however, the fact that she has a position on one side or the other of any question involving a divided medical community had no bearing in any of the facts found to be true or untrue in this case. Her assertion, to various patients and suggested at the hearing that those proceedings, and other problems she may have had with colleagues or hospitals are attempts to punish her for her views was not established by any evidence whatsoever.

What was established is the fact that among other reasons for her conduct, her zeal for her personal bill of fare got in the way of sound medical judgment in some cases and the standard of care in others; and her overblown view of her own knowledge and skill caused her to act incompetently in others.

The standard of proof applied in this case was the standard required by Ettinger v. BMQA (1982) 135 Cal.App.3d 858; and except as hereinabove found to be true, all other factual allegations of the Accusation, and assertions by the respondent are found to be unproved or surplusage. All motions, defenses, and arguments not hereinabove determined, or disposed of on the hearing record, are found to be not established by the facts or law.

* * * * *

Pursuant to the foregoing findings of fact, the Administrative Law Judge makes the following determination of issues:

I

Cause exists to suspend or revoke respondent's license pursuant to Business and Professions Code Sections 2227, 2228, 2229 and 2234, in that she has committed acts constituting unprofessional conduct, as follows:

A. Pursuant to Section 2234(b) of said Code by reason of Finding XVII.

B. Pursuant to Section 2234(d) of said Code by reason of Findings XX, XXI, and XXVIII.

C. Pursuant to Sections 725 and 2234, by reason of Findings XXIX and XLVIII.

D. Pursuant to Section 2234(a) by reason of Findings IX, XVI, XIX, LIII, and LVI, and each of them.

E. Pursuant to Section 2234(e) by reason of Findings VIII, XV, XVIII, XXXVIII, XLIV, XLVII, L, LII, and LV, and each of them.

F. Pursuant to Sections 810(a) and 2234, by reason of Finding LVII and each item therein.

G. Pursuant to Section 2234(c), by reason of Findings XVII, XXVIII, and XLIII.

Consideration has been given to the Board's most recent policies and guidelines, the charges proven and unproven, the total effect of respondent's conduct, and the protection of the public health, safety, and welfare.

* * * * *

WHEREFORE, THE FOLLOWING ORDER is hereby made:

The physician's and surgeon's certificate number G-035472, heretofore issued to respondent V. Georges Hufnagel, is hereby revoked as to each determination of issues set forth herein and as to all of them; provided, however, said revocations, and each of them, are hereby stayed for a period of five (5) years from and after the effective date of the order herein, and respondent is placed on probation for said period, upon the following terms and conditions:

1. Respondent shall comply with all laws of the United States, the State of California and its political subdivisions, and all rules and regulations of the Board of Medical Quality Assurance of the State of California.

2. Respondent shall report in person to the Division of Medical Quality or its agents or medical consultants at such meetings or interviews as may be directed by reasonable notice during the period of probation.

3. Respondent shall submit to the Division of Medical Quality, at quarterly intervals, a declaration under penalty of perjury on forms provided by the Division, to the effect that she is fully and faithfully complying with all the terms and conditions of this probation. The first report shall be due when ordered by the Executive Director.

4. Respondent shall comply with the Division's probation surveillance program. In connection therewith, respondent shall make herself and/or any facility over which she has cognizance available for inspection by authorized representatives of the Division at any time for the purpose of verifying respondent's compliance with the terms of his probation.

5. (a) Within 60 days of the effective date of this decision, respondent shall take and pass an oral clinical examination in the field of obstetrics, gynecology and fertility, to be administered by the Division or its designee. If respondent fails this examination, respondent must take and pass a

re-examination consisting of a written as well as an oral clinical examination. The waiting period between repeat examinations shall be at three month intervals until success is achieved. The Division shall pay the cost of the first examination and respondent shall pay the cost of any subsequent re-examination.

(b) If respondent fails the first examination, respondent shall cease the practice of medicine until the re-examination has been successfully passed, as evidenced by written notice to respondent from the Division.

6. Respondent shall take and complete a course in Medical Ethics. Within 60 days of the effective date of this decision, respondent shall select and submit a course to the Division for its prior written approval.

7. Within 60 days of the effective date of this decision, respondent shall submit to the Division for its prior written approval, a community service program in which respondent shall provided free medical service on a regular basis to a community or charitable facility or agency for at least twenty (20) hours per month for the first twenty-four (24) months of probation.

8. Within 60 days of the effective date of this decision, respondent shall submit to the Division for its prior approval a plan of practice in which respondent's practice and billing procedures shall be monitored by another physician in respondent's field of practice, who shall provide periodic reports to the Division.

If the monitor quits, or is no longer available, respondent shall not practice until a new monitor has been substituted, through nomination by respondent and approval by the Division.

9. In the event respondent should leave California to reside or to practice outside the State, respondent shall immedidately notify the Division, in writing, of the dates of departure and return. Periods of residency or practice outside California shall not apply to the reduction of this probationary period.

Upon full compliance with the terms and conditions herein set forth and upon the expiration of the probationary period, the certificate shall be restored to its full privileges; provided, however, that in the event respondent violates or fails to comply with any of the terms and conditions hereof, the Division of Medical Quality, after

notice to respondent and opportunity to be heard, may terminate this probation and reinstitute the revocation or make such other order modifying the terms of probation herein as it deems just and reasonable in its discretion.

If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

DATED: 30 Dec 88

ROBERT A. NEHER
Administrative Law Judge
Office of Administrative Hearings

RAN:hk