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

In the Matter of the Accusation Against: PAUL FLEISS, M.D. 1824 Hillhurst Avenue Los Angeles, CA 90027 Physician's and Surgeon's Certificate No. A28858 Respondent.	Case No. 17-2005-169843 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. Paul Fleiss, M.D. (Respondent) was issued an Osteopathic Physician's and Surgeon's Certificate Number 2-A2845, on or about July 9, 1962. He subsequently elected to utilize designation of M.D. rather than D.O. Consequently, on or about March 21, 1975, the Medical Board of California issued Physician's and Surgeon's Certificate Number A28858 to Paul Fleiss, M.D. This Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2007, unless

renewed.

JURISDICTION

3. This Accusation is brought before the Division of Medical Quality (Division) for the Medical Board of California, Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

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

FIRST CAUSE FOR DISCIPLINE

Gross Negligence (Patient E.S.)

6. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in the care and treatment of a pediatric patient E.S. The circumstances are as follows:

7. E.S. was first seen by Respondent, a pediatrician, on or about December 5, 2001, approximately two days after she was born. Respondent knew this patient's mother personally, and was aware that the mother was HIV positive. Respondent also was aware that the mother was breast feeding E.S. At no time did Respondent acknowledge or document in the medical record any consideration of E.S. or her mother's HIV status.

8. On or about December 5, 2001, or at any subsequent time during which E.S. was Respondent's patient, Respondent did not record in the patient's history known information of the mother's HIV status. Respondent did not take steps to have E.S. undergo HIV testing, and/or failed to make a record of the parents' refusal to undergo such testing. Even though HIV may be transmitted through the breast milk of an HIV positive mother, Respondent failed to advise and/or document that he did advise the mother to discontinue breast feeding until E.S.'s HIV status could be determined. Respondent failed to offer and/or document that he offered to treat E.S. with antiviral therapy to minimize the possibility of HIV being transmitted through breast milk. In fact, the mother breast fed E.S. for three years, with Respondent's knowledge and approval.

9. On or about December 5, 2001, a newborn hearing screening test that was performed at Respondent's office was abnormal in the left ear, but Respondent made no comment in regard to this test result in the medical record and took no steps to evaluate or treat it.

10. E.S. was next seen on or about January 10, 2002, for complaints of cough and fever, and a diaper rash which has been present since birth. This rash was not described in the medical record, nor was any treatment of it documented. The patient was diagnosed with a viral infection and monialiasis. During the January 10, 2002 visit, Respondent prescribed or gave a "Z-pack," also known as antibiotic Zithromax to the patient's mother, without obtaining any history, performing any examination, or documenting a diagnosis of any illness, or any other indication.

11. On January 21, 2002, Respondent saw E.S. for a well-baby examination, although he failed to document whether the patient was timely reaching her developmental milestones. No detailed physical examination was documented; Respondent only documented "normal P.E." in the chart without further explanation. The diaper rash which was documented during the previous visit has not changed, and Respondent diagnosed it as candidiasis. No cause of candidiasis was given and/or documented in the patient's chart. No treatment of candidiasis was given or documented.

12. On May 20, 2002, Respondent saw E.S. for a well-baby examination at approximately 6 months of age. Once again, Respondent took and/or recorded no history and failed to obtain and/or record whether the patient was reaching her developmental milestones. The immunizations were refused by the parents, and the physical examination was recorded only as "normal P.E." with no further details The child was 5 ½ months old, her height and weight were at 78th and 30th percentile respectively. Respondent approved E.S. to begin solid food.

13. On December 3, 2002, Respondent saw E.S. for a well-baby visit at approximately 12 months of age. Once again, Respondent took no history and failed to obtain and/or record the patient's developmental milestones. The physical examination was recorded only as "normal P.E." with no further details A blood test for anemia, normally done at the 9

month visit, was not performed and no refusal to undergo this testing was documented. Immunizations were refused by the parents. The patient's height and weight were recorded at 50th and 25th percentile respectively.

14. The patient returned for a checkup at approximately 21 months of age, on or about September 5, 2003. Her height was recorded at 60th percentile, but her weight has fallen below the 5th percentile for her age, at 20 pounds 5 ounces. Her temperature was 100. Respondent failed to obtain and/or record any information in regard to the patient's diet or further investigate the patient's limited weight gain. Respondent took no history, did not obtain and/or record developmental milestones, or address the patient's elevated temperature. Respondent wrote in the medical record that the patient was healthy and recorded his physical examination only as "normal P.E." with no further details. His diagnosis was "WCC," well child checkup.

15. The patient returned to see Respondent again at approximately 26 months of age, on or about February 2, 2004. Respondent documented in the medical record that E.S. was able to walk, talk, that she was "happy" and "playful." The patient's weight, however, was still below the 5th percentile, at 21pounds 6 ounces. No height measurement was obtained. Respondent documented that in addition to breast feeding, the child ate fruits and vegetables, and had a "normal P.E." with no further details. Respondent noted that the mother once again refused immunizations, and he cleared the patient to attend "mother and me" classes. A hemoglobin test, usually done at 2 years of age, was not performed during this visit, and no refusal to undergo this testing was documented.

16. On January 21, 2005, the patient was seen once again when she was approximately 3 years and 1 month old. The patient weight was 23.9 pounds and her height was 34.25 inches; both were significantly below the 5th percentile. E.S. was being breast fed. Respondent failed to obtain a history or to chart any specific developmental milestones. Despite a list of foods the child was eating in addition to breast milk, no explanation for her limited weight gain was considered and/or documented in the medical record. The diagnosis was "WCC."

17. E.S. was seen for the last time on or about April 30, 2005. Respondent did not examine the patient, although he approved the treatment performed by his nurse practitioner, and co-signed the chart. The chart was documented with an intermittent history of fever and a "raspy cough." It was documented that the child "seems to have rapid, shallow breathing." E.S. was diagnosed with bilateral otitis media and bronchitis. Amoxicillin was given to the parents, although no dosage is indicated in the record. The record indicates that the parents refused to give Amoxicillin at this time. The parents were advised to increase fluid intake, honey and lemon, and to use eucalyptus as needed. The parents were instructed to monitor the child for signs of infection and respiratory distress, and to telephone Respondent or go to the Emergency Room if there was an increase in the symptoms. Respondent observed the patient after the visit with the nurse practitioner and stated that E.S. was acting normally.

18. E.S. passed away approximately 2 ½ weeks later, on May 18, 2005, at the age of 3. According to the coroner's Autopsy Report, her death was caused by pneumocystis carinii pneumonia due to Acquired Immunodeficiency Syndrome (AIDS). Signs of HIV encephalopathy were present as well.

19. Each of the followings acts and/or omissions of Respondent in the care and treatment of patient E.S. constitutes an extreme departure from the standard of care:

A. Respondent failed to record and/or take into consideration during the patient's course, the patient's known high risk of exposure to HIV.

B. On or about December 5, 2001, Respondent was aware that the patient's mother was HIV positive and was breast feeding the patient, but he failed to recommend, or document parental refusal of, testing to establish whether E.S. was HIV positive.

C. Respondent failed to advise the mother against breast feeding.

D. Throughout the course of E.S., Respondent failed to obtain and/or clearly document the patient's developmental milestones, and failed to describe in any detail the patient's history and physical examinations.

E. Throughout the course of E.S., Respondent failed to address E.S.'s failure to thrive.

F. On or about April 30, 2005, Respondent approved of treatment which failed to conduct an adequate diagnostic work-up, and failed to obtain a chest x-ray.

G. On or about January 10, 2002, Respondent prescribed or gave a "Z-pack," to the patient's mother, for the mother's use, without obtaining any history, performing any examination, or documenting a diagnosis of any illness, or any other indication.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence (Patient Z.L.))

20. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in the care and treatment of a pediatric patient Z.L. The circumstances are as follows:

21. Z.L., a four-year-old boy, was first seen by Respondent on or about May 17, 2004, for a "second opinion consult" of "treatment options." Respondent was told by the parents that Z.L.'s mother and Z.L were HIV positive and that he was being treated by a doctor specializing in HIV at UCSD. Respondent failed to document this fact in the patient's record. The patient's weight was 30 pounds, 8 ounces, and his height was 37.5 inches. Both were below the 5th percentile for the patient's age. At the time of the visit the patient had an oral temperature of 102.6. Pulse oximeter reading was 96 and pulse 154. Blood pressure and growth plots were not done. No past history nor history of allergies, no history of the present febrile illness and no mention of any physician following this patient in the past was taken and/or recorded in the medical record. No physical exam was performed. Respondent was given a number of previous laboratory tests, as well as chest CT scan and an X-ray report, by the parents. The laboratory tests indicated that Z.L. suffered from a severely depressed immune system. The CT scan and X-ray reports indicated that "extensive, innumerable bilateral small pulmonary nodules" were present. The laboratory and x-ray reports were placed in Z.L.'s medical record, but no history regarding these documents was taken and/or recorded in the patient's chart. Respondent did not recall seeing these tests. The patient was not examined or treated during this visit. Respondent's records indicate that the Z.L. was recommended bath and Advil during this visit, and Advil was

refused by the parents. Even though the May 17, 2004 visit with Z.L. was for "a second opinion consult" Respondent did not document the opinion or consultation he gave to Z.L. or to his parents.

22. Z.L. was seen in respondent's office by Respondent's nurse-practitioner, on or about May 26, 2004, for complaints of worsening cough and congestion. The patient's weight was 30 pounds, 1 ounce, and his height was 37.5 inches. Both were below the 5th percentile for the patient's age. Penicillin and sulfa antibiotic drug allergies were documented at this time. The patient was given Zithromax for an ear infection. Oral lesions were also noted to be present. Respondent approved the treatment performed by his nurse practitioner, and co-signed the chart.

23. On or about June 4, 2004, Respondent requested a chest x-ray, indicating that the patient had a history of resolved pneumonia, although no mention of this request, or the history of resolved pneumonia was made anywhere in the patient's record. The x-ray report, indicating that "moderately severe diffuse bilateral infiltrates" were present, was faxed to Respondent's office on June 7, 2004. Respondent took no action in response to this grossly abnormal x-ray.

24. Z.L. was next seen at the Respondent's office on June 9, 2004. The patient's weight was 30 pounds, 8 ounces, and his height was recorded as 37 inches. Both were below the 5th percentile for the patient's age. Respondent did not address the abnormal x-ray which was faxed to his office two days prior, nor did he mention previous diagnostic imaging studies showing abnormal chest x-ray and C.T. scan. Respondent recorded in the chart that the patient was "doing great" after taking the antibiotics, that the patient had no fever, was no longer wheezing, but did have an occasional cough. Respondent's diagnosis was a resolving ear infection and rule out chronic disease. Even though respondent was aware that the patient was suffering from HIV/AIDS, and an abnormal chest x-ray report was previously faxed to his office, no mention of what "chronic disease" Respondent suspected was documented in the record. A record of various vitamin supplements being taken by the patient was made. Respondent ordered vitamin testing, which was performed on June 15, 2004. No mention of why these tests were

ordered was made in the patient's record.

25. Respondent made an entry in the patient's chart on April 20, 2005. Respondent did not see the patient on that date, and has not seen the patient since June 9, 2004. The chart note indicates that the patient's mother asked Respondent questions, that she was respectful and not argumentative, that she was genuinely interested in the best interest of the child and was willing to follow instructions and medical recommendations. Respondent made entries in the medical record that Z.L.'s mother "is not neurocognitively impaired[,]" although Respondent never performed, and was not aware of any neurocognitive testing being performed on the patient's mother. Respondent also made a record that the patient Z.L. "had no physical signs of chronic disease[,]" although Respondent had not seen this patient for over 11 months, and knew or should have known that the patient was afflicted with HIV/AIDS, previously had a grossly abnormal chest x-ray, and was significantly under-weight. In his interview with the Medical Board of California, Respondent indicated that these statements were written at the request of the patient's mother, although these statements were written as statements of fact, with no indications of a request having been made by the patient's mother that these statements be included in the patient's record; and that these statements related to the issue of custody of Z.L. According to the office note dated April 20, 2005 Respondent referred this patient to an HIV/AIDS specialist at that time.

26. Each of the following acts and/or omissions of Respondent in the care and treatment of patient Z.L. constitutes an extreme departure from the standard of care:

A. Throughout the entire time Respondent cared for Z.L., Respondent failed to obtain and/or record a relevant history of the presenting complaint, past history of illness, hospitalization or relevant family history.

B. On or about May 17, 2004, Respondent failed to address this immuno-compromised patient's extremely febrile state.

C. During the time Respondent cared for Z.L., Respondent failed to prepare a growth chart for the patient.

D. During the time Respondent cared for Z.L., Respondent failed to perform

and/or document a physical examination of the patient.

E. During the time Respondent cared for Z.L., Respondent failed to acknowledge and take into account abnormal laboratory test results and chest x-rays and CT scans pertaining to patient Z.L.

F. On or about June 7, 2004, Respondent failed to act on an abnormal chest x-ray, a report of which was faxed to the Respondent's office.

G. During the time Respondent cared for Z.L., Respondent failed to order appropriate laboratory tests to enable him to establish a differential diagnosis of patient Z.L.

H. During the time Respondent cared for Z.L., Respondent failed to establish a differential diagnosis of patient Z.L.

I. On or about June 9, 2004, Respondent ordered vitamin level testing for patient Z.L. without indication and or explanation of the reasons why this testing was ordered.

J. On or about April 20, 2005, Respondent recorded a diagnosis that the patient's mother was not neurocognitively impaired, with no empirical reason for such a statement.

K. On or about April 20, 2005, Respondent recorded that Z.L. had no signs of a chronic disorder.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts -- patients E.S. and Z.L.)

27. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated acts of negligence in the care and treatment of a pediatric patients Z.L. and E.S. The circumstances are as follows:

28. Allegations of paragraphs 6 through 26 are incorporated herein by reference.

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FOURTH CAUSE FOR DISCIPLINE

(Incompetence – all patients)

29. Respondent is subject to disciplinary action under section 2234, subdivision (d), of the Code in that he exhibited lack of knowledge and/or ability in regard to the care and treatment of pediatric patients who are afflicted with HIV/AIDS. The circumstances are as follows:

30. The allegations in paragraphs 6 through 26 are incorporated herein by reference.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

31. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate records relating to his provision of services to patients. The circumstances are as follows:

32. The allegations in paragraphs 6 through 26 are incorporated herein by reference.

DISCIPLINE CONSIDERATIONS

33. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about May 22, 1996, in a prior disciplinary action based upon a criminal conviction, entitled In the Matter of the Accusation Against Paul Fleiss, M.D. before the Medical Board of California, in Case Number 17-1995-49900. Respondent's license was revoked, the revocation was stayed, and his license was placed on probation with various terms and conditions. That decision is now final and is incorporated by reference as if fully set forth. The probationary period has ended.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number

A28858, issued to Paul Fleiss, M.D.;

2. Revoking, suspending or denying approval of Paul Fleiss, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering Paul Fleiss, M.D. to pay the Division of Medical Quality the costs of probation monitoring;

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

DATED: September 13, 2006

DAVID T. THORNTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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