

**STATE OF OHIO  
THE STATE MEDICAL BOARD  
CEDRIC M. BAUTISTA, M.D.  
PERMANENT SURRENDER OF CERTIFICATE  
TO PRACTICE MEDICINE AND SURGERY**

I, CEDRIC M. BAUTISTA, M.D., am aware of my rights to representation by counsel, the right of being formally charged and having a formal adjudicative hearing, and do hereby freely execute this document and choose to take the actions described herein, after being fully advised by legal counsel.

I, CEDRIC M. BAUTISTA, M.D. do hereby voluntarily, knowingly, intelligently, and permanently surrender my certificate to practice medicine and surgery, No. 35-048934, to the State Medical Board of Ohio, thereby permanently relinquishing all rights to practice medicine and surgery in Ohio. This surrender shall be effective as of midnight, May 17, 2000.

I understand that as a result of the surrender herein that I am no longer permitted to practice medicine and surgery in any form or manner in the State of Ohio.

I agree that I shall be ineligible for, and shall not apply for, reinstatement of certificate to practice medicine and surgery No. 35-048934 or issuance of any other certificate pursuant to Chapters 4730. or 4731., Ohio Revised Code, on or after the date of signing of this Surrender of Certificate to Practice Medicine and Surgery. Any such attempted reapplication shall be considered null and void and shall not be processed by the Board.

I stipulate and agree that I am taking the action described herein in lieu of further formal disciplinary proceedings in accordance with R.C. Chapter 119 and R.C. 4731.22 for the matters described in the Notice of Opportunity for Hearing dated February 9, [2000]. I further stipulate and admit the allegations in said Notice, which is attached hereto in Exhibit A and incorporated herein by this reference.

I, CEDRIC M. BAUTISTA, M.D. hereby release the State Medical Board of Ohio, its members, employees, agents and officers, jointly and severally, from any and all liability arising from the within matter.

This document shall be considered a public record as that term is used in Section 149.43, Ohio Revised Code.

Further, this information may be reported to appropriate organizations, data banks and governmental bodies.

Surrender of Certificate  
page 2

Signed this 8 day of May, 2000.

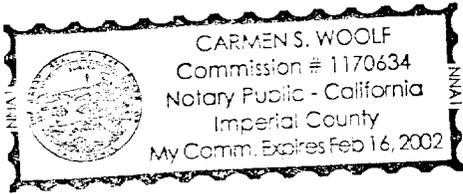
Cedric M. Gault

Signature of Physician

Carla Valdez  
Witness

Sara Oyeda  
Witness

Sworn to and subscribed in my presence, this 8<sup>th</sup> day of May, 2000.



Carmen S. Woolf  
NOTARY PUBLIC

(This form must be either witnessed OR notarized.)

Accepted by the State Medical Board of Ohio:

Anand G. Garg  
ANAND G. GARG, M.D.  
Secretary

05/24/00  
DATE

Raymond J. Albert  
RAYMOND J. ALBERT  
Supervising Member

5/24/00  
DATE



# State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/466-3934 • Website: [www.state.oh.us/med/](http://www.state.oh.us/med/)

February 9, <sup>2000</sup>~~1999~~

Cedric M. Bautista, M.D.  
P.O. Box 2010  
El Centro, California 92244

Dear Doctor Bautista:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand or place you on probation for one or more of the following reasons:

- (1) On or about May 4, 1999, the Division of Medical Quality of the Medical Board of California (hereinafter the "California Board") adopted a Decision, effective June 3, 1999, in which it found that you were guilty of gross negligence in your treatment of one patient. The California Board found unprofessional conduct with respect to your clinical decision making and your charting of your treatment of this patient.

Pursuant to that Decision, the California Board revoked your physician and surgeon certificate, stayed the revocation and placed your certificate on probation for a period of two (2) years. The probationary terms and conditions include, but are not limited to, that within 60 days of the effective date of the California Board Decision, and on an annual basis thereafter, you submit to the California Board for prior approval an education program or course of not less than 40 hours per year, for each year of probation in addition to the Continuing Medical Education requirements for re-licensure.

Further, you were required to reimburse the California Board \$6,942.04 for its costs of investigation and prosecution and to pay the costs of probation monitoring each and every year of probation. A copy of the California Board Decision is attached hereto and fully incorporated herein.

The California Board Decision as alleged in paragraph (1) above, constitutes "[a]ny of the following actions taken by the state agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatry, or the limited branches of medicine in another state, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a

*Mailed 2/10/00*

Cedric M. Bautista, M.D.

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license; imposition of probation; or issuance of an order of censure or other reprimand;" as that language is used in Section 4731.22(B)(22), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty (30) days of the time of mailing of this notice.

You are further advised that you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty (30) days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, effective March 9, 1999, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Anand G. Garg, M.D.  
Secretary

AGG/jag  
Enclosures

CERTIFIED MAIL # Z 233 896 559  
RETURN RECEIPT REQUESTED

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

MEDICAL BOARD OF CALIFORNIA  
I do hereby certify that  
this document is true  
and correct copy of the  
original on file in this  
office.

In the Matter of the Accusation )  
Against: )  
NORMAN E. BARON, M.D. )  
Certificate # G-26743 )  
Respondent. )

*Carol Thomas* 1-19-80  
SIGNED DATE  
*Asst. Custodian of Records*  
TITLE

File No: 10-1997-77723

In the Matter of the Accusation )  
Against: )  
CEDRIC BAUTISTA, M.D. )  
Certificate # A-37997 )  
Physician's Assistant )  
Supervisor Approved License # SA 27237 )  
Respondent. )

File No: 10-1997-77724

DECISION

The attached Stipulation is hereby adopted by the Division of Medical Quality of the Medical Board of California as its Decision in the above-entitled matter.

This Decision shall become effective at 5:00 p.m. on June 3, 1999.

It is so ordered May 4, 1999.

DIVISION OF MEDICAL QUALITY  
MEDICAL BOARD OF CALIFORNIA

*Ira Lubell M.D.*  
Ira Lubell, M.D.  
Chair - Panel A

**BEFORE THE  
DIVISION OF MEDICAL QUALITY  
MEDICAL BOARD OF CALIFORNIA  
STATE OF CALIFORNIA**

In the Matter of the Accusation Against: )	Case No. 10-97-77723
)	)
Norman E. Baron, M.D. )	OAH No. L-1998080234
608 G Street )	)
Brawley, CA 92227 )	)
)	)
Physician's and Surgeon's )	)
Certificate No. G 26743 )	)
)	)
Respondents. )	)
)	)
<hr/> In the Matter of the Accusation Against: )	Case No. 10-97-77724
)	)
CEDRIC BAUTISTA, M.D. )	OAH No. L-1998080233
P.O. Box 2010 )	)
El Centro, CA 92244 )	)
)	)
Physician's and Surgeon's )	)
Certificate No. A 37997 )	)
)	)
Physician's Assistant )	)
Supervisor Approved License )	)
No. SA 27237 )	)
)	)
Respondent. )	)
)	)
<hr/>	)

**PROPOSED DECISION**

On January 11, 12, 13, 14, 15, 19 and 20, 1999, in San Diego, California, Stephen E. Hjelt, Administrative Law Judge, Office of Administrative Hearings, heard this matter. These two accusation hearings were consolidated for trial by agreement of the parties pursuant to Government Code section 11507.3.

Steven Zeigen, Deputy Attorney General, represented the complainant Medical Board of California.

Mark L. Brandon, Esq., of Grace, Brandon, Hollis and Ramirez, LLP, represented Norman E. Baron, M.D.

Cary Miller, Esq., of Luce, Forward, Hamilton and Scripps, LLP represented Cedric M. Bautista, M.D.

Evidence was received and the record was held open for submission of further evidence. On January 25, 1999, the parties submitted a packet of documents which were better quality photocopies of various pages of the medical records. These were marked collectively as exhibit 10 and received in evidence. The record was then closed and submitted for decision on January 25, 1999.

### FACTUAL FINDINGS

1. Accusation No. 10-97-77723 against Norman E. Baron, M.D. was filed by the complainant on or about July 27, 1998. It was filed by Ron Joseph in his official capacity as the Executive Director of the Medical Board of California, and not otherwise.
2. Accusation No. 10-97-77724 against Cedric Bautista, M.D. was filed by the complainant on or about July 27, 1998. It too was filed by Ron Joseph in his official capacity as the Executive Director of the Medical Board of California, and not otherwise.
3. Both physicians were charged with violations of the Medical Practice Act with respect to the care and treatment they rendered to one patient during one hospitalization from April 21 through April 30, 1996. Both physicians were surgeons handling on-call trauma at Pioneers Memorial Hospital in Brawley, California.
4. The following three paragraphs give a brief overview of both respondents' involvement with this patient. More detailed findings follow. Dr. Baron, M.D. was the on-call surgeon covering the emergency room of this hospital on April 21, 1996. He was called to see patient Creed B., a 46-year old male who had been involved in a serious dune buggy accident. Dr. Baron assumed care of this patient and treated him from April 21 until April 25. Then, Dr. Bautista took over the care of the patient from April 26 until April 29 due to a previously scheduled vacation of Dr. Baron. Dr. Baron resumed care of the patient on April 30, 1996.
5. The patient died on April 30, 1996.
6. Dr. Baron took a history and performed a physical of the patient. The patient complained of pain in the upper abdomen and low back. X ray of the spine revealed a compression fracture at L-1. CAT scan of the abdomen revealed possible fluid around the liver consistent with a possible hepatic injury. Dr. Baron admitted the patient to the intensive

care unit for observation. At the time of admission to the intensive care unit, Dr. Baron was aware that the patient was an insulin dependent diabetic. When Dr. Bautista took over care, he was aware the patient was an insulin dependent diabetic.

7. Complainant charged Dr. Baron with multiple violations of the Medical Practice Act. These are enumerated verbatim from the accusation as follows:

- A. Respondent failed to either aggressively treat Creed's diabetes personally or to obtain a medical consultation to assist in this aspect of Creed's [care].
- B. Respondent failed to place Creed on a regimen of insulin which included repeated adjustment to accommodate Creed's needs.
- C. Respondent failed to properly follow Creed's diabetic status.
- D. Respondent failed to note and/or be aware of Creed's low CO<sub>2</sub> level.
- E. Respondent failed to deal with Creed's low CO<sub>2</sub> level.
- F. Respondent failed to order follow-up chemistries.
- G. Respondent failed to monitor Creed's electrolytes, and, in particular, his bicarbonate even though a low level indicates acidosis.
- H. Respondent failed to monitor Creed's repeatedly negative input and output.
- I. Respondent failed to perform and/or note daily chest examinations.
- J. Respondent failed to properly monitor Creed's respiratory status.
- K. Respondent failed to note the presence of persistent tachycardia and increased respiratory rate.
- L. Respondent failed to take steps to appropriately evaluate Creed's persistent tachycardia and increased respiratory rate.

Dr. Baron was also charged with failing to maintain accurate and adequate records in violation of Business and Professions Code section 2266. The three specific instances are verbatim from the Accusation as follows:

- A. Respondent failed to chart Creed's low CO<sub>2</sub> level.
- B. Respondent failed to note daily chest examinations.

C. Respondent failed to note the presence of persistent tachycardia and increased respiratory rate.

8. On April 26, 1996, Dr. Baron left town and Dr. Bautista assumed the care of patient Creed. He cared for the patient through April 29, 1996. Dr. Baron was to return on April 30 and resume the care of the patient. The patient died on April 30, 1996 before Dr. Baron saw him.

Dr. Bautista is likewise charged with multiple violations of the Medical Practice Act. He is charged with Gross Negligence, Incompetence and Repeated Negligent Acts as follows, taken verbatim from the Accusation:

A. Respondent failed to either aggressively treat the Creed's diabetes personally or to obtain a medical consultation to assist in this aspect of the Creed's [condition].

B. Respondent failed to place Creed on a regimen of insulin which included repeatedly adjustment to accommodate Creed's needs.

C. Respondent failed to properly follow the Creed's diabetic status.

D. Respondent failed to deal properly with Creed's low CO<sub>2</sub> level.

E. Respondent failed to order appropriate follow up chemistries.

F. Respondent failed to recognize possible signs of diabetic ketoacidosis and take aggressive steps to reverse the condition.

G. Respondent failed to monitor Creed's input and output.

H. Respondent failed to perform and/or note daily chest examinations.

I. Respondent failed to properly monitor Creed's respiratory status.

J. Respondent failed to note the presence of persistent tachycardia and increased respiratory rate.

K. Respondent failed to take steps to appropriate evaluate Creed's persistent tachycardia and increased respiratory rate.

Dr. Bautista was also charged with the failure to maintain accurate and adequate records in violation of Business and professions Code section 2266. He was specifically charged as follows, taken verbatim from the Accusations:

- A. Respondent failed to chart Creed's low CO2 level.
- B. Respondent failed to note daily chest examinations.
- C. Respondent failed to note the presence of persistent tachycardia and increased respiratory rate.

9. **CONTEXT** The care and treatment of a patient never occurs in a vacuum. There is always a context that gives character and understanding to the events surrounding the physician-patient relationship. In order to understand what happened in the treatment of patient Creed B. from April 21 to April 30, 1996, it is necessary to understand context. Although the conduct of both respondents is the focus of this proceeding, their professional conduct cannot be understood and evaluated without an analysis of the actions of others, including the patient and nursing staff at the hospital in a rural setting in Brawley, in the Imperial Valley of California.

Both respondents defended their actions vigorously on the merits. Neither attempted to blame others for the care and treatment rendered. Despite the obvious ammunition available, neither attempted to demonize the patient and blame him for the outcome.

10. **THE DIFFICULT PATIENT** There are some comfortable generalities that hide and conceal the real life decisions that physicians must make. It is a correct assertion that the same standard of care applies whether a patient is rich or indigent, even though we all know that wealth buys a standard of practice not usually available to the poor. It is a correct assertion that the standard of care is the same whether a patient is cooperative and docile or unpleasant and uncooperative, even though we all know that patient lack of compliance can substantially increase the burdens of the physician. It is a correct assertion that the standard of care is the same in a small community in rural California as in a large city, even though we all know there are great differences in the availability of certain resources.

In this case we are faced with care rendered in a rural hospital in Brawley, California, to a most difficult, demanding and uncooperative patient. A complete and accurate assessment of the professional conduct of both respondents must start with this most difficult patient. The only glimpse we have of him is from the entries in the hospital record and in the testimony of those who interacted with him during his hospital stay. This is, no doubt, a one sided view of a very complicated man. However, it is the only view we have and it is not a terribly attractive one.

The findings made about this patient are not made lightly and are not meant to offend those who loved him. To say this patient was unpleasant and difficult is an understatement. He increased the burdens on all those who were part of the health care team. Nevertheless,

being disruptive and uncooperative is not normally a capital offense and Creed B. did not deserve to die as he did.

There is an old saw that goes like this - the squeaky wheel gets the grease. Loosely translated, you don't get taken care of unless you speak up. Complaints don't get resolved if they are never voiced. So much for old saws. It did not apply during this fateful hospitalization.

Treating this patient was anything but easy. He pulled his IV's out, he refused to eat, he resisted wearing an orthopedic back brace. He was abusive to the nurses, refused to cooperate with the physical therapist, demanded more and more pain medication and complained constantly about the care he was receiving. It got so bad that on April 27, a nurse from the hospital called his friend Trina Mattingly and asked her to call Creed B. and tell him to please cooperate with the doctors and nurses. On two separate occasions, nurses found evidence that he had been self-medicating with Vicodin and Comtrex. He complained to his friend Trina that the nurses were keeping him from seeing his doctor and were ignoring him. He told her the nurse said to stop whining and crying and grow up. On occasion his speech was slurred and he was hallucinating, but this was no doubt a function of his heavy analgesic use and not related to his diabetic condition. The PCA (patient controlled analgesia) had to be discontinued because he was making excessive use of it.

Much of the pleasure of medical practice comes from talking and interacting with patients. Unfortunately, some patients, for a variety of reasons, do not enjoy the relationship and punish those they come in contact with. Some patients view themselves as abused and neglected and use a variety of manipulative tools to get their needs met. Some, like Creed B., use intimidation to get needs met. It is beyond the record to fathom all the reasons unique to Creed B. that made him such a difficult patient. But some general truths seem to apply. Illness, injury and disability create in people a gradual loss of hope as well as feelings of discomfort and helplessness. When a patient begins to recognize they are ill, they experience a series of emotional reactions that include anxiety, anger frustration and fear. Their debilitated condition may make them confront their own mortality. They may act in very unpleasant ways.

Difficult patients can arouse very strong negative feelings in the physician. They are taught about this in medical school and it is reinforced in their specialty training. The mental health folks have a fancy name for it, counter transference. The bottom line is the doctor is trained to recognize these feelings and deal with them so that they do not interfere with patient care. The doctor is the expert in this and is charged with the responsibility to understand the dynamics involved. No chart note will ever say, "patient is a well developed, well-nourished, white male, in no acute distress, but he is a jerk and I wish he would find someone else to treat him." Even though it will not appear in a chart note, there is no practitioner out there who has not thought this at some time in their career. When this occurs, the doctor must deal with his own feelings, lest they get in the way of competent care.

By the same token a patient like Creed B. makes medical decision making potentially much more difficult. Not only must you deal with the normal challenges of diagnosis and treatment but must do so without the benefit of patient cooperation and compliance. Here, there was a failure to deal appropriately with signs of abnormality, partly due to the attention given to the patient's demanding and difficult personality. It was easier and more comfortable to focus on the patient's pain than to take a careful look at all the significant data that was present or available through routine testing.

The true test of a physician's competence and skill comes, not in treating the routine, but in dealing with the difficult and the challenging. This is how a physician demonstrates his ability. The standard of care does not require heroic medicine or superhuman insight. It demands only that a physician be fully engaged by the clinical task at hand rather than a passive bystander.

11. THE EMERGENCY ROOM ADMISSION The 46-year-old patient was admitted to the emergency room of Pioneers Memorial Hospital shortly before midnight on April 21, 1996. He was seen initially in the ER by Dr. Jeffrey Farmin. Relevant portions of his Emergency Room Note, (exhibit 5, AGO 88 and 89 in evidence) are as follows:

“ . . .  
PAST MEDICAL HISTORY: This could be rather extensive. This gentleman has a past history of insulin dependent diabetes mellitus. He states that he takes about 30 units of regular insulin a day, but then he states he is not sure, so we don't really know. He additionally states that he takes Vicodin and Darvocet. He gives an additional history of having had lumbar back surgery about six months ago, but again he doesn't know what exactly was done. As far as allergies go, he states he is allergic to Morphine and Codeine, yet he does state he takes Vicodin and Darvocet, so there is a questionable history there. He denies any alcohol abuse. Currently today he has not had his insulin.

EXAMINATION: Vitals: Pulse in the 90 to 100 range; respirations 20 to 22; O2 saturations on room air in the upper 90's; blood pressure initially was 174/109; this did increase to 179/113 at which he was given some sublingual Procardia. Further examination shows the skull, scalp and face to be atraumatic. The chest is atraumatic. The abdomen, however, is fairly quiet, with some mild tenderness throughout. There are no bruises or abrasions.

“ . . .  
During the course of the work-up, the patient continued to complain of very severe pain, although it was very difficult to tell exactly where he was hurting.

LAB DATA: Laboratory studies were done and he initially had a white count of 13.6, hemoglobin 14 and hematocrit 42. Chemistries showed a sodium of 137, potassium 3.4, chloride 96, CO2 25m BUN 7m creatinine 0.8; however, his serum glucose was 449 and he was given 5 units of regular insulin through his IV,

resulting in a later 422 blood sugar and at that point was given 12 units subcu. as per the admission sliding scale insulin regimen prescribed for him.

**X-RAYS:** The patient had his cervical spine cleared and then had a CT scan of the abdominal region. This did show gastric and proximal small bowel inflation suggestive of ileus and also there was perhaps a compression type fracture of L1, that does not otherwise appear displaced. Additionally, there were irregular calcifications of the kidneys, possibly stones, and a questionable small amount of bleeding around the liver.

**ASSESSMENT:** 1) BLUNT ABDOMINAL TRAUMA WITH LIVER  
CONTUSION  
2) POSSIBLE LUMBAR FRACTURE  
3) INSULIN DEPENDENT DIABETES MELLITUS

**UNDER POOR CONTROL**

**PLAN:** Dr. Norman Baron, who is on-call this evening, is consulted and he has come in and has admitted this patient to the Intensive Care Unit for further observation as necessary."

12. Dr. Baron did examine the patient in the ER and his History and Physical, (exhibit 5, AGO 93 and 94 read in relevant part:

"...

**PAST MEDICAL HISTORY:** The patient states he is allergic to Morphine and Codeine. It is difficult to extract a history from him. He complains of pain and is not very cooperative. The patient has had a back injury in the past. He denies any surgical procedures. He is an insulin dependent diabetic, taking 60 units of insulin a day, 30 units in the morning and 30 units in the evening, and has been diabetic for many years. The patient states he has no other health problems.

...

**PHYSICAL EXAMINATION**

**GENERAL:** The patient is a well-nourished, well-developed male, alert and oriented in all three spheres.

**EYES:** Pupils are equal and reactive to light. Sclerae are clear.

**EARS, MOUTH, NOSE AND THROAT:** Negative. No hemotympanum present.

**NECK:** Supple. There are no deformities. Carotids are palpable and without bruits. The neck veins are not distended.

**CHEST:** Symmetrical. There is no obvious trauma. No bruises or abrasions are noted. There is no tenderness to the anterior chest.

**LUNGS:** Clear to percussion and auscultation.

**HEART:** Rate and rhythm are normal. There are no murmurs.

When the body does not produce enough insulin to maintain a normal blood sugar level or when cells can't appropriately respond to the presence of insulin, diabetes is the result. Insulin dependent diabetes refers to a condition in which the body produces little or no insulin. Diabetes is a serious medical condition and unless treated appropriately can result in damage to multiple organ systems and can be fatal. A serious complication of untreated diabetes is the development of diabetic ketoacidosis. Cells are not able to use glucose in the blood without insulin so they turn to other sources for energy. Fat cells are broken down which produces ketones which are toxic chemicals that make the blood acidotic. Without treatment, ketoacidosis can lead to coma and death.

The main goal of treatment is to keep blood sugar levels as close to a normal range as possible. It is nearly impossible to keep an insulin dependent diabetic always within a normal range but with good patient effort one can come close. The more out of control the blood sugar levels are the greater the likelihood of immediate as well as long term complications. This is not a friendly disease and places challenges on the clinician as well as on the patient. Cooperation and coordination between doctor and patient is essential to the satisfactory treatment of insulin dependent diabetes.

This patient was a diabetic in poor control. He was not a terribly compliant patient during his hospital stay and the weight of the evidence suggests that he was not a terribly compliant patient outside of the hospital.

One of the special problems presented by diabetics in any clinical setting is their increased susceptibility to infection. They are in general more subject to infection than non-diabetics and this is well known to any reasonably competent physician. In a patient like Creed B., a physician must be careful to identify the signs of infection and also take steps in care and treatment to reduce the risk that an infection will occur.

In this case the patient expired on April 30, 1996 due to pneumonia. There was very convincing testimony from Dr. Howard Robin, a well-qualified pathologist, regarding the cause of death and the stage of the infectious process in the patient when he died. He agreed with the conclusions of the autopsy report that the cause of death was acute laryngo tracheo bronchitis and right lower lobe pneumonia. He further testified and established that pneumonia is a disease that has received a tremendous amount of study over the last 200 years and pathologists are able to identify with good accuracy how long such an infectious process has been present. In this patient, based upon the evidence available post-mortem, the pneumonia was about 18 hours old at the time of death and thus began between 10 p.m. and midnight on April 29, 1996. Before that time there was no pneumonia for any doctor to diagnose. The O<sub>2</sub> saturation at midnight was 99% and this is strongly suggestive of no pneumonia in the lungs.

Insulin dependent diabetics are generally treated by specialists in Internal Medicine or Endocrinologists. Because of the common complications of diabetes, a fair number end up needing the services of surgeons. The experts who testified in this case estimated that about 20% of their surgery patients are diabetics. One of the disputed issues in this case relates to

the claim that both respondents should have called in for an internal medicine consult, or treated the this patient far more aggressively.

The standard of care does not require a surgeon such as Dr. Baron or Dr. Bautista to refer a patient such as Creed B. to an internist or endocrinologist unless they are not able to properly manage the medical condition during the time the patient remains under their surgical care. Most surgeons manage their surgical patient's diabetes without the need for any consult. Only if the diabetic condition is out of control would the standard of care call for such a referral.

It was not a violation of the standard of care for either surgeon to assume the medical management of the patient's diabetes during the hospitalization. Dr. Baron managed it well enough during the time he was in charge. Dr. Bautista did not, and this was a violation of the standard of care.

17. The totality of the evidence in this case does not support a finding of unprofessional conduct against Dr. Baron either with respect to his clinical decision making or his charting. Both could be improved on but neither rise to a level to justify the imposition of administrative discipline.

18. The totality of the evidence in this case does support a finding of unprofessional conduct against Dr. Bautista both with respect to his clinical decision making and his charting. There is a wide area of acceptable conduct in the treatment of a patient like Creed B. A physician is not subject to discipline simply because he guesses wrong about a disease or treatment. Only when his wrong guess or lack of any guess is well below the standard of care is the imposition of administrative discipline warranted. There are other social (word of mouth in the community), professional (peer review) and legal (civil litigation) institutions that are designed to deal with physician error.

Dr. Bautista's chart notes are a very revealing glimpse into his relatively superficial involvement with the dynamic clinical picture posed by this patient so far into his hospitalization. His responses to the changing status of the patient showed some awareness of a problem but he did not properly explore why this patient was still in the hospital 5, 6, 7 and 8 days after admission while exhibiting the range of signs and symptoms in this case. He acted more like a babysitter than a physician. Rather than effectively dealing with a sick patient, he chose to write on his progress note "Do not disturb. No problem."

Furthermore, Dr. Bautista's charting was very poor. His chart notes were misleading because they conveyed almost nothing of value about the patient. Taken as a whole his progress notes and orders did not comply with the standard of care.

19. All the experts who testified were well qualified and of assistance to the Administrative Law Judge.

Dr. Daniel Einhorn, an endocrinologist and expert on diabetes testified and established that in all probability this patient did not have ketoacidosis at any time while in the hospital. His reasoning was very persuasive but he was quick to acknowledge that we will never know for sure. This is a good example of the limits of even exceptionally qualified experts' opinion. Even the best and the brightest must acknowledge the limits of their testimony because there is always an incomplete universe of data both for the clinician and later for the expert.

Drs. Paul Black and Joshua Bardin were more persuasive and their opinions more reasoned regarding the conduct of Dr. Bautista than Dr. Baron. The patient may or may not have been in "dire straits" on April 27, as Dr. Bardin testified, but no matter how you characterize it this insulin dependent patient, seven days into a hospitalization with a CO<sub>2</sub> that has dropped from 25 at admission to 12 needs both immediate aggressive treatment but also a competent search for a cause. This patient was sick and getting sicker and simply to assume (as Dr. Bautista did) that he was stable and all that was needed was to treat his pain missed the boat. Dr. Bautista's efforts, as found in his physician's orders, were too little and too late. Even though he took steps to deal with the clinical picture, these were directed only to the symptoms and did not in any way seek to find a cause. This was an extreme departure from the standard of care.

Dr. Donley McReynolds testified on behalf of Dr. Bautista and Dr. Leo Murphy testified on behalf of Dr. Baron. Both are well-qualified surgeons. Both were knowledgeable about the facts. Both testified sincerely. Dr. McReynolds characterized Dr. Bautista's responses as reasoned and appropriate. He couched his opinion in terms such as "the patient's blood sugar level was within an appropriate range during the four days Dr. Bautista treated." His testimony was not convincing based on the entire factual record. It is one thing to walk down the street and get hit on the head by a brick falling from the 45<sup>th</sup> floor of a nearby building. You die and it's just bad luck. Creed B. did not die because of the proverbial brick falling from the sky. He died because Dr. Bautista, among other agents of causation, was far too passive in his husbandry. It may well be that the nursing staff bears a large share of the responsibility for this patient's death. However, their conduct was not the primary focus of these charges.

All experts, whether they are compensated a lot or a little have a strong investment in the opinions they render. The fact that respondents' experts were compensated much more generously than complainant's means only that the pool of competent experts available to respondents in these actions is far larger than what is available to complainant. It is an imperfect system that asks a doctor to lose money in order to testify on behalf of the Medical Board of California. There are many competent and honorable physicians who feel it is their responsibility to the profession to testify for \$100 per hour in these cases. But there is a vast pool of excellent physicians, devoted to their profession, who won't because they lose

money. When they can earn \$250 to \$500 per hour (or more) in their office or examining room there is a strong disincentive to being an expert for far less.

20. Complainant established that it incurred actual and reasonable costs for investigation and enforcement of this action against Dr. Baron in the amount of \$7194.57.

21. Complainant established that it incurred actual and reasonable costs for investigation and enforcement of this action against Dr. Bautista in the amount of \$6942.04.

### LEGAL CONCLUSIONS

1. Jurisdiction over the practice of Medicine in California is vested in the Medical Board of California. The body of law that governs the practice of medicine in California is found in the California Business and Professions Code and is known as the Medical Practice Act.

2. Business and Professions Code section 2227 provides, in pertinent part, that the Division may revoke, suspend for a period not to exceed one year, or place on probation and order the payment of probation monitoring cost, the license of any licensee who has been found guilty under the Medical Practice Act.

3. Business and Professions Code section 2234 provides, in pertinent part, that the Division shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

“....

“(b) Gross negligence

“(c) Repeated negligent acts

“(d) Incompetence

....”

4. Business and Professions Code section 2266 provides, in pertinent part, that the failure of a physician and surgeon to make and maintain accurate and adequate records constitutes unprofessional conduct.

5. Business and Professions Code section 125.3 provides, in part, that the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

6. Section 16.01 of the 1997/1998 Budget Act of the State of California provides, in pertinent part, that: (a) no funds appropriated by this act may be expended to pay any Medi-Cal claim for any service performed by a physician while that physician's license is under suspension or revocation due to a disciplinary action of the Medical Board of California; and (b) no funds appropriated by this act may be expended to pay any Medi-Cal claim for any surgical service or other invasive procedure performed on any Medi-Cal beneficiary by a physician if that physician has been placed on probation due to a disciplinary action of the Medical Board of California related to the performance of that specific service or procedure on any patient, except in any case where the board makes a determination during its disciplinary process that there exists compelling circumstances that warrant continued Medi-Cal reimbursement during the probationary period.

7. With respect to this claim, it is important to understand the context in which care was rendered as well as the dictates of the law underpinning the administrative process. The administrative process is premised on the belief that a physician must act within the standard of care or face penalties for deviation. This is so even if a given deviation from the standard of care causes no direct patient harm. This is so, also, when patient harm is caused by persons or instrumentalities other than or in addition to a given respondent. The focus is specifically on the conduct of the respondent. By the same token, patient harm does not automatically equate with unprofessional conduct. The fact that there is a poor outcome or that a given patient dies does not transform or transmute conduct from innocent to inimical. Physicians are to be judged not by the quality of patient outcome in a particular case but by the relative quality of the decision making regarding the patient's care. In this case a nine-day hospitalization for a traumatic back injury led to a very unexpected death. It is no surprise that questions would be asked about what happened to this patient and why.

The demand for answers and accountability led to the filing of a civil suit for damages against the respondents and others. The focus of our attention here is quite different from the focus on conduct in our civil courts when malpractice suits are litigated. In the superior court there is explicit recognition that culpability may be shared and thus there is the concept of joint tortfeasors, as well as comparative fault. In the administrative process, there are no analogs to the notion of shared responsibility, although Government Code section 11507.3 provides for the consolidation of related actions, as this case shows. Either the standard of care has been violated or it hasn't and it does not matter whether patient harm is present for a determination that unprofessional conduct has occurred.

The notion of context (the how and the why of the case) does, however, matter greatly in the administrative forum. This is so because of the unique goal of the administrative

process. The process exists solely as a vehicle to enhance and insure the delivery of quality medical care to the people of the state of California. It does not exist to punish, to make an example of anyone nor does it exist to make political statements.

The context creates the framework for the disciplinary recommendations that the law requires the administrative law judge to make in the Proposed Decision. Only by carefully analyzing the context in which events occur can the administrative law judge make reasonable and sensible recommendations regarding what form of discipline, if any, is necessary to (1) protect the public, and (2) if possible, rehabilitate the physician so that eventually the physician can practice safely without restriction or oversight.

Context matters greatly in this case for the purpose of determining whether either respondent violated the standard of care but also to determine, even if the standard of care was violated, are the deviations the type that require that the Medical Board of California restrict respondents' practice. Not all violations of the standard of care require disciplinary oversight. A finding of negligence in a civil lawsuit does not mean that a respondent should be subject to administrative discipline.

Civil suits require proof by a mere preponderance of the evidence, which translates to a simple question, is it more likely than not a given doctor deviated from the standard of care. In other words, a plaintiff in a civil action can prevail if he establishes a 51% quantum of proof. Despite the high profile that many such suits command, they are basically private disputes between individuals or business entities that can result in the transfer of money from one party to the other. It is a form of money changing that provides, on occasion, great theatre but does not do much to advance important social interests such as public protection.

The administrative process recognizes that there are exceedingly important social interests involved in regulating and overseeing the professional actions of physicians. Medicine is the type of undertaking that, when done with skill, can result in wondrous good. When done poorly, it can result in grave harm. The Medical Practice Act seeks to promote two important social interests. The first, public protection, is the most obvious. The second is to allow the practice of medicine to be done in a way that does not require a doctor to be a guarantor of results or to be absolutely liable for all adverse outcomes. By its laws and regulations, it should not place extreme burdens on the profession that cannot be met by adherence to a well-recognized standard of care. In other words, the prudent but erroneous exercise of medical judgement is not grounds for discipline as long as the doctor operated within the standard of care.

There are a variety of things that distinguish the administrative process from the civil. There are two special elements designed to insure that the public is protected from unsafe doctors and doctors due process rights are protected. The first is that there must be a finding of an extreme departure from the standard of care. The second is that proof must be established by clear and convincing evidence. These are not impediments to fair and just decisions, as some suggest. They are in fact essential components of a process of adjudication designed to reduce the risk of error. Erroneous results in administrative

adjudication involving physicians can have devastating consequences for consumers and doctors. By linking the requirement of extreme departure from the standard of care with proof by clear and convincing evidence, the administrative process demands that a case be proved in a way that gives the process a form of integrity that is lacking in other types of adjudication.

8. **CHARTING** Charting and record keeping have traditionally been viewed as an ancillary and almost unimportant part of the medical enterprise. Despite the existence of Business and Professions Code section 2266, establishing the standard of care in most disciplinary cases is elusive and problematic. There appears to be almost no uniform accepted practice in the community of California physicians nor does there appear to be a uniform practice in individual medical specialties. And yet everybody seems to have an opinion about physician charting.

Charting will always challenge a busy physician to balance the need for brevity with the need to record that which is important. How do you record the essence and leave out the superfluous? It is easy to agree on the generalities. No one would quibble with the requirement that a physician record be accurate and adequate. The terms are vague and general and provide almost no guidance about how one determines chart accuracy or adequacy.

The bromides that have grown up around the issue really amount to nothing more than buzzwords used for rhetorical flourish. It is so easy for an expert to pontificate about variations of ... "if it isn't charted, it didn't happen." This may make it easier for an expert to form an opinion since it gives the appearance of a rock solid foundation. It is easier to opine when you can conclude that an event, act, thought process or judgment did not occur because it was not charted.

The fact of the matter is that medical students are barraged with the message that if you don't chart something it didn't happen as a way to impress on them the importance of a good chart note. But the trier of fact in a case like this cannot simply apply this formula to the facts to reach a result. If that were all that was required, then it would be satisfactory to simply have a technician apply the formula. What this means is that a failure to chart an act, event, thought process or judgment makes the fact finding process infinitely more difficult. It creates corresponding problems both for the complainant and respondent. It is very difficult to argue cogently from a silent record. And yet we know that a great deal of decent medical decision making occurs without it being committed to the patient's chart.

Charting is an ever-present issue for all doctors who work in a busy clinical setting. There is never enough time, always too much to deal with before the next patient is seen. Any experienced trial counsel should be able to make some mileage over a doctor's notes. It's like shooting fish in a barrel. This is compounded by the inexorable pressure of managed care to do more in less time. Even good doctors sometimes forget to make adequate and accurate records. It is for this reason that the question of adequacy of charting should not be

based solely on an isolated event or entry. The totality of the record keeping is the more appropriate standard for review.

There is a broad range of appropriate when it comes to evaluating the legal sufficiency of a physician's chart notes. Depending on the type of practice the physician has, a given set of notes could be viewed as too sparse, adequate or overly detailed. An internist's chart notes are characteristically more detailed than a surgeon's.

Most physicians view charting and record keeping as a nuisance and only grudgingly take the time to enter findings. In a sense, this is understandable. A doctor rarely views his chart notes as an active part of his treatment of a patient. However, this is terribly shortsighted. A physician's chart notes are integral to the process of patient care.

Chart notes exist to further the skillful treatment of the patient. They are kept to record the essence of what the physician observes and postulates. They are kept to record data and to describe and to record the process of active diagnosis. They are kept because memory alone is inadequate as a chronicle of the course of treatment, the progression of disease or the amelioration of patient distress.

Even if memory were adequate as a repository of past actions, charting would still be required. It is common for patients to be seen by many physicians over their life course. Patients move, change health care plans, doctors retire and die. It is common for a new physician to need a historical referent for a new patient. It is unreasonable to expect that a patient could give a new physician all necessary information about a past illness or treatment. This information may be exceedingly important. This information will be available and accessible if a physician simply does his job and keeps accurate and adequate chart notes.

What does it mean to note significant findings? Dr. Black, one of the complainant's experts, admitted that a doctor is not required to put into the record his thought process regarding a patient, but in recognizing an abnormality, a doctor must indicate, either directly or indirectly, what he thinks is the genesis and what he plans to do about it. A doctor does this directly when he notes the substance of such a finding in his progress notes. He does it indirectly, if his notations are solely in the physician orders. In other words, a physician discharges his obligation under Business and Professions Code section 2266 if another physician can pick up the chart and reasonably understand the direction that treatment is headed and deduce in general the doctor's game plan. If a significant abnormality is noted a doctor must indicate, directly or indirectly, what he thinks is the genesis and what he plans to do about it.

9. EXPERT WITNESSES The Administrative Law Judge has followed and relied on California Evidence Code section 720 and BAJI 8<sup>th</sup> 2.40 and 2.41 as well as the factors set forth in the Factual Findings above in determining the persuasiveness of the numerous experts who testified.

BAJI 2.40 reads in relevant part:

“A witness who has special knowledge, skill, experience, training or education in a particular subject has testified to certain opinions. Any such witness is referred to as an expert witness. In determining what weight to give any such opinion, you should consider the qualifications and believability of the witness, the facts or materials upon which each opinion is based, and the reasons for each opinion.

An opinion is only as good as the facts and reasons on which it is based. If you find that any such fact has not been proved, or has been disproved, you must consider that in determining the value of the opinion. Likewise, you must consider the strengths and weaknesses of the reasons on which it is based...”

BAJI 2.41 deals with Weighing Conflicting Expert Testimony. It reads as follows:

“In resolving the conflict in the testimony of expert witnesses, you should weigh the opinion of one expert against that of another. In doing this, you should consider the qualifications and believability of each witness, the reasons for each opinion and the matter upon which it is based.”

The BAJI instructions are important tools to be used by the administrative law judge. They were developed and are used in all civil jury trials in California. They are guides for the trier of fact in resolving the contested issues in a lawsuit. The Administrative Law Judge has multiple functions in a case such as this. One function is to sit on behalf of the Board and make factual findings. As such the Administrative Law Judge acts in a fashion analogous to a jury and BAJI provides excellent guidance.

#### **10. NORMAN E. BARON, M.D.**

1. Cause was not established to impose discipline on respondent for the violation of Business and Professions Code section 2234 (c) repeated negligent acts, by virtue of Factual Findings 9-19.

2. Cause was not established to impose discipline on respondent for the violation of Business and Professions Code section 2234 (b) gross negligence, by virtue of Factual Findings 9-21.

3. Cause was not established to impose discipline on respondent for violation of Business and Professions Code section 2234 (d) incompetence, by virtue of Factual Findings 9-21.

4. Cause was not established to impose discipline on respondent for the violation of Business and Professions Code section 2266, failure to maintain adequate and accurate records, by virtue of Factual Findings 9-21.

5. Cause was not established to impose an award of costs under Business and Professions Code section 123.5, by virtue of Factual Findings 9-21.

#### **11. CEDRIC M. BAUTISTA, M.D.**

1. Cause was established to impose discipline on respondent for the violation of Business and Professions Code section 2234 (b), gross negligence, by virtue of Factual Findings 9-21.

2. Cause was not established to impose discipline on respondent for the violation of Business and Professions Code section 2234 (c) repeated negligent acts, by virtue of Factual Findings 9-21.

3. Cause was not established to impose discipline on respondent for the violation of Business and Professions Code section 2234 (d), incompetence, by virtue of Factual Findings 9-21.

4. Cause was established to impose an award of costs under Business and Professions Code section 125.3 in the amount of \$6,942.04, by virtue of Factual Findings 9-21.

#### **ORDER**

1. Physician and Surgeon Certificate issued to respondent Cedric M. Bautista, M.D., is revoked. However, the revocation is stayed and his certificate is placed on probation for a period of two years subject to the following terms and conditions. Within 15 days after the effective date of this Decision the respondent shall provide the Division, or its designee, proof of service that respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent or where respondent is employed to practice medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to respondent.

- A. **OBEY ALL LAWS-** Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

- B. **QUARTERLY REPORTS-** Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.
- C. **PROBATION SURVEILLANCE PROGRAM COMPLIANCE-** Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of his addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record. Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.
- D. **INTERVIEWS WITH THE DIVISION-** Respondent shall appear in person for interviews with the Division, its designee or its designated physician upon request at various intervals and with reasonable notice.
- E. **TOLLING-** In the event respondent should leave California to reside or to practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the Division or its designee in writing within ten days of dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition will not apply to the reduction of the probationary period.
- F. **COMPLETION OF PROBATION-** Upon successful completion of probation, respondent's certificate shall be fully restored.
- G. **VIOLATION OF PROBATION-** If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation or Petition to Revoke Probation 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.
- H. **COST RECOVERY-** The respondent is hereby ordered to reimburse the Division the amount of \$6,942.04 before the termination of probation for its costs of investigation and prosecution. Failure to reimburse the Division's cost

of investigation and prosecution shall constitute a violation of the probationary order, unless the Division agrees in writing to payment by an installment plan because of financial hardship.

- I. LICENSE SURRENDER- Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation respondent may voluntarily tender his certificate to the Board. The Division reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will no longer be subject to the terms and conditions of probation.
- J. PROBATION COSTS- Respondent shall pay the costs associated with probation monitoring each and every year of probation. Such costs shall be payable to the Division at the end of each fiscal year. Failure to pay such costs shall be considered a violation of probation.
- K. EDUCATIONAL COURSE- Within 60 days of the effective date of this decision, and on an annual basis thereafter, respondent shall submit to the Division or its designee for its prior approval an educational program or course to be designated by the Division, which shall not be less than 40 hours per year, for each year of probation. This program shall be in addition to the Continuing Medical Education requirements for re-licensure. Following the completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of continuing medical education of which 40 hours were in satisfaction of this condition and were approved in advance by the Division or its designee. This is the type of respondent who could benefit from an assessment of his clinical skills in treating diabetic patients in his surgical practice at a facility such as PACE, at UCSD Medical School. The other area of deficiency relates to his charting and could be assessed and dealt with at PACE also.

- 2. Accusation No. 10-97-77723 filed against Norman Baron, M.D. is dismissed.

Dated: April 9, 1999

  
STEPHEN E. HJELT  
Administrative Law Judge  
Office of Administrative Hearings