

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. )

Physician's and Surgeon's )  
Certificate No. A28858 )

Respondent. )  
\_\_\_\_\_ )

File No. 17-2005-169843

DECISION

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

This Decision shall become effective at 5:00 p.m. on October 8, 2007.

IT IS SO ORDERED September 7, 2007.

MEDICAL BOARD OF CALIFORNIA

By: Cesar A. Aristeiguieta, M.D.  
Cesar A. Aristeiguieta, M.D., F.A.C.E.P.  
Chair  
Panel A  
Division of Medical Quality

1 EDMUND G. BROWN JR., Attorney General  
of the State of California  
2 PAUL C. AMENT  
Supervising Deputy Attorney General  
3 E. A. JONES III, State Bar No. 71375  
Deputy Attorney General  
4 California Department of Justice  
300 So. Spring Street, Suite 1702  
5 Los Angeles, CA 90013  
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7 Attorneys for Complainant

8 **BEFORE THE**  
9 **DIVISION OF MEDICAL QUALITY**  
10 **MEDICAL BOARD OF CALIFORNIA**  
11 **DEPARTMENT OF CONSUMER AFFAIRS**  
12 **STATE OF CALIFORNIA**

13 In the Matter of the Accusation Against:

14 PAUL FLEISS, M.D.  
1824 Hillhurst Avenue  
Los Angeles, CA 90027

15 Physician's and Surgeon's Certificate No.  
A28858

16 Respondent.

Case No. 17-2005-169843

OAH No. L2006100478

**STIPULATED SETTLEMENT AND  
DISCIPLINARY ORDER**

17  
18  
19 In the interest of a prompt and speedy settlement of this matter, consistent with the  
20 public interest and the responsibility of the Division of Medical Quality, Medical Board of  
21 California of the Department of Consumer Affairs (Division), the parties hereby agree to the  
22 following Stipulated Settlement and Disciplinary Order which will be submitted to the Division  
23 for approval and adoption as the final disposition of the Accusation

24 PARTIES

25 1. David T. Thornton (Complainant) is the Executive Director of the Medical  
26 Board of California. He brought this action solely in his official capacity and is represented in  
27 this matter by Edmund G. Brown Jr., Attorney General of the State of California, by E. A. Jones  
28 III, Deputy Attorney General.



1 CULPABILITY

2 8. Respondent admits the truth of each and every charge and allegation in the  
3 Fifth Cause for Discipline (Failure to Maintain Adequate Records) in Accusation No.  
4 17-2005-169843.

5 9. Respondent agrees that his Physician's and Surgeon's Certificate is subject  
6 to discipline and he agrees to be bound by the Division's imposition of discipline as set forth in  
7 the Disciplinary Order below.

8 CIRCUMSTANCES IN MITIGATION

9 10. Respondent reaffirms his policy of referring to a specialist patients who  
10 present with HIV/AIDS issues. Respondent voluntarily successfully completed the 17.25 hour  
11 medical record keeping course of the Physician Assessment and Clinical Education Program at  
12 the University of California, San Diego Medical School early in these proceedings. The Medical  
13 Board of California received over a hundred letters from generations of patients and parents  
14 supporting Respondent, including declarations from the mothers of the two patients who are the  
15 subjects of the accusation. Respondent maintains that he properly counseled the parents of the  
16 patients regarding the standard of care for dealing with HIV/AIDS issues.

17 RESERVATION

18 11. The admissions made by herein are only for the purposes of this  
19 proceeding, or any other proceedings in which the Division, or other professional licensing  
20 agency is involved, and shall not be admissible in any other criminal or civil proceeding.

21 CONTINGENCY

22 12. This stipulation shall be subject to approval by the Division. Respondent  
23 understands and agrees that counsel for Complainant and the staff of the Medical Board of  
24 California may communicate directly with the Division regarding this stipulation and settlement,  
25 without notice to or participation by or his counsel. By signing the stipulation, understands and  
26 agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time  
27 the Division considers and acts upon it. If the Division fails to adopt this stipulation as its  
28 Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or

1 effect, except for this paragraph, it shall be inadmissible in any legal action between the parties,  
2 and the Division shall not be disqualified from further action by having considered this matter.

3 OTHER MATTERS

4 13. The parties understand and agree that facsimile copies of this Stipulated  
5 Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same  
6 force and effect as the originals.

7 14. In consideration of the foregoing admissions and stipulations, the parties  
8 agree that the Division may, without further notice or opportunity to be heard by respondent,  
9 issue and enter the following Disciplinary Order:

10 DISCIPLINARY ORDER

11 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No.  
12 A28858 issued to Paul Fleiss, M.D. is revoked. However, the revocation is stayed and  
13 respondent is placed on probation for thirty-five (35) months on the following terms and  
14 conditions.

15 1. EDUCATION COURSE Within 60 calendar days of the effective date of  
16 this Decision, and on an annual basis thereafter, respondent shall submit to the Division or its  
17 designee for its prior approval educational program(s) or course(s) which shall not be less than  
18 15 hours per year, for each year of probation. The educational program(s) or course(s) shall be  
19 aimed at correcting any areas of deficient practice or knowledge as noted in the accusation and  
20 shall be Category I certified, limited to classroom, conference, or seminar settings. The  
21 educational program(s) or course(s) shall be at respondent's expense and shall be in addition to  
22 the Continuing Medical Education (CME) requirements for renewal of licensure. Following the  
23 completion of each course, the Division or its designee may administer an examination to test  
24 respondent's knowledge of the course. Respondent shall provide proof of attendance for 40 hours  
25 of continuing medical education for each year of probation of which 15 hours were in satisfaction  
26 of this condition.

27 2. MEDICAL RECORD KEEPING COURSE Within 60 calendar days of  
28 the effective date of this decision, respondent shall enroll in a course in medical record keeping,

1 at respondent's expense, approved in advance by the Division or its designee. Failure to  
2 successfully complete the course during the first 6 months of probation is a violation of  
3 probation.

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

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

12 3. MONITORING - PRACTICE Within 30 calendar days of the effective  
13 date of this Decision, respondent shall submit to the Division or its designee for prior approval as  
14 a practice monitor the name and qualifications of one or more licensed physicians and surgeons  
15 whose licenses are valid and in good standing, and who are preferably American Board of  
16 Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or  
17 personal relationship with respondent, or other relationship that could reasonably be expected to  
18 compromise the ability of the monitor to render fair and unbiased reports to the Division,  
19 including, but not limited to, any form of bartering, shall be in respondent's field of practice, and  
20 must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

21 The Division or its designee shall provide the approved monitor with copies of the  
22 Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of  
23 receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit  
24 a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands  
25 the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor  
26 disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan  
27 with the signed statement.

28 Within 60 calendar days of the effective date of this Decision, and continuing

1 throughout probation, respondent's practice shall be monitored on a quarterly basis by the  
2 approved monitor. Respondent shall make all records available for immediate inspection and  
3 copying on the premises by the monitor at all times during business hours, and shall retain the  
4 records for the entire term of probation.

5 The monitor(s) shall submit a quarterly written report to the Division or its  
6 designee which includes an evaluation of respondent's performance, indicating whether  
7 respondent's practices are within the standards of practice of medicine and whether respondent is  
8 practicing medicine safely.

9 It shall be the sole responsibility of respondent to ensure that the monitor submits  
10 the quarterly written reports to the Division or its designee within 10 calendar days after the end  
11 of the preceding quarter.

12 If the monitor resigns or is no longer available, respondent shall, within five  
13 calendar days of such resignation or unavailability, submit to the Division or its designee, for  
14 prior approval, the name and qualifications of a replacement monitor who will be assuming that  
15 responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement  
16 monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be  
17 suspended from the practice of medicine until a replacement monitor is approved and prepared to  
18 assume immediate monitoring responsibility. Respondent shall cease the practice of medicine  
19 within three calendar days after being so notified by the Division or designee.

20 In lieu of a monitor, respondent may participate in a professional enhancement  
21 program equivalent to the one offered by the Physician Assessment and Clinical Education  
22 Program at the University of California, San Diego School of Medicine, that includes, at  
23 minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of  
24 professional growth and education. Respondent shall participate in the professional enhancement  
25 program at respondent's expense during the term of probation.

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

1                   4.     NOTIFICATION Prior to engaging in the practice of medicine, the  
2 respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or  
3 the Chief Executive Officer at every hospital where privileges or membership are extended to  
4 respondent, at any other facility where respondent engages in the practice of medicine, including  
5 all physician and locum tenens registries or other similar agencies, and to the Chief Executive  
6 Officer at every insurance carrier which extends malpractice insurance coverage to respondent.  
7 Respondent shall submit proof of compliance to the Division or its designee within 15 calendar  
8 days.

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

11                   5.     SUPERVISION OF PHYSICIAN ASSISTANTS During probation,  
12 respondent is prohibited from supervising physician assistants.

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

16                   7.     QUARTERLY DECLARATIONS Respondent shall submit quarterly  
17 declarations under penalty of perjury on forms provided by the Division, stating whether there  
18 has been compliance with all the conditions of probation. Respondent shall submit quarterly  
19 declarations not later than 10 calendar days after the end of the preceding quarter.

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

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



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

4 9. INTERVIEW WITH THE DIVISION, OR ITS DESIGNEE Respondent  
5 shall be available in person for interviews either at respondent's place of business or at the  
6 probation unit office, with the Division or its designee, upon request at various intervals, and  
7 either with or without prior notice throughout the term of probation.

8 10. RESIDING OR PRACTICING OUT-OF-STATE In the event respondent  
9 should leave the State of California to reside or to practice, respondent shall notify the Division  
10 or its designee in writing 30 calendar days prior to the dates of departure and return. Non-  
11 practice is defined as any period of time exceeding 30 calendar days in which respondent is not  
12 engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions  
13 Code.

14 All time spent in an intensive training program outside the State of California  
15 which has been approved by the Division or its designee shall be considered as time spent in the  
16 practice of medicine within the State. A Board-ordered suspension of practice shall not be  
17 considered as a period of non-practice. Periods of temporary or permanent residence or practice  
18 outside California will not apply to the reduction of the probationary term. Periods of temporary  
19 or permanent residence or practice outside California will relieve respondent of the responsibility  
20 to comply with the probationary terms and conditions with the exception of this condition and  
21 the following terms and conditions of probation: Obey All Laws and Probation Unit  
22 Compliance.

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

1                    11.     FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT

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

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

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

17                    12.     COMPLETION OF PROBATION Respondent shall comply with all  
18     financial obligations (e.g., probation costs) not later than 120 calendar days prior to the  
19     completion of probation. Upon successful completion of probation, respondent's certificate shall  
20     be fully restored.

21                    13.     VIOLATION OF PROBATION Failure to fully comply with any term or  
22     condition of probation is a violation of probation. If respondent violates probation in any respect,  
23     the Division, after giving respondent notice and the opportunity to be heard, may revoke  
24     probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to  
25     Revoke Probation, or an Interim Suspension Order is filed against respondent during probation,  
26     the Division shall have continuing jurisdiction until the matter is final, and the period of  
27     probation shall be extended until the matter is final.

28                    14.     LICENSE SURRENDER Following the effective date of this Decision, if


1 respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy  
 2 the terms and conditions of probation, respondent may request the voluntary surrender of  
 3 respondent's license. The Division reserves the right to evaluate respondent's request and to  
 4 exercise its discretion whether or not to grant the request, or to take any other action deemed  
 5 appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender,  
 6 respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the  
 7 Division or its designee and respondent shall no longer practice medicine. Respondent will no  
 8 longer be subject to the terms and conditions of probation and the surrender of respondent's  
 9 license shall be deemed disciplinary action. If respondent re-applies for a medical license, the  
 10 application shall be treated as a petition for reinstatement of a revoked certificate.

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

17  
 18 ACCEPTANCE

19 I have carefully read the above Stipulated Settlement and Disciplinary Order and  
 20 have fully discussed it with my attorney, Gary Wittenberg. I understand the stipulation and the  
 21 effect it will have on my Physician and Surgeon's Certificate. I enter into this Stipulated  
 22 Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be  
 23 bound by the Decision and Order of the Division of Medical Quality, Medical Board of  
 24 California.

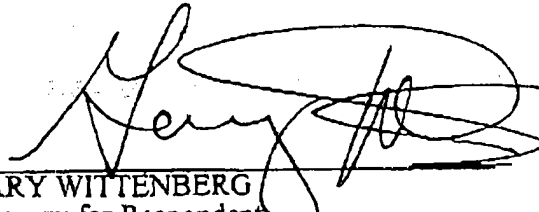
25 DATED: 07/12/2007

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 27   
 28 PAUL FLEISS, M.D.  
 Respondent

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I have read and fully discussed with Paul Fleiss, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 7-18-07

  
GARY WITTENBERG  
Attorney for Respondent

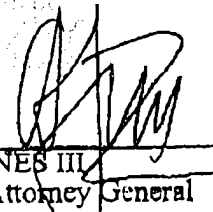
ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Division of Medical Quality, Medical Board of California of the Department of Consumer Affairs.

DATED: 7/16/07

EDMUND G. BROWN JR., Attorney General  
of the State of California

PAUL C. AMENT  
Supervising Deputy Attorney General

  
E. A. JONES III  
Deputy Attorney General  
Attorneys for Complainant

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1 I have read and fully discussed with Paul Fleiss, M.D. the terms and conditions  
2 and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve  
3 its form and content.

4 DATED: \_\_\_\_\_

5

6

7 GARY WITTENBERG  
Attorney for Respondent

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9

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ENDORSEMENT

11

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13

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully  
submitted for consideration by the Division of Medical Quality, Medical Board of California of  
the Department of Consumer Affairs.

14

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DATED: 7/16/07

16

EDMUND G. BROWN JR., Attorney General  
of the State of California

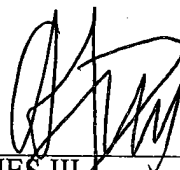
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PAUL C. AMENT  
Supervising Deputy Attorney General

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E. A. JONES III  
Deputy Attorney General

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Attorneys for Complainant

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**Exhibit A**

**Accusation No. 17-2005-169843**

1 BILL LOCKYER, Attorney General  
of the State of California  
2 VLADIMIR SHALKEVICH, State Bar No. 173955  
Deputy Attorney General  
3 California Department of Justice  
300 So. Spring Street, Suite 1702  
4 Los Angeles, CA 90013  
Telephone: (213) 897-2148  
5 Facsimile: (213) 897-9395

6 Attorneys for Complainant

FILED  
STATE OF CALIFORNIA  
MEDICAL BOARD OF CALIFORNIA  
SACRAMENTO September 13, 20 06  
BY Valerie M. O'Brien ANALYST

7  
8 **BEFORE THE**  
9 **DIVISION OF MEDICAL QUALITY**  
10 **MEDICAL BOARD OF CALIFORNIA**  
11 **DEPARTMENT OF CONSUMER AFFAIRS**  
12 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 17-2005-169843

12 PAUL FLEISS, M.D.  
1824 Hillhurst Avenue  
13 Los Angeles, CA 90027

**ACCUSATION**

14 Physician's and Surgeon's Certificate No.  
A28858

15 Respondent.

16  
17 Complainant alleges:

18  
19 PARTIES

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

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

1 renewed.

2  
3 JURISDICTION

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

8 4. Section 2234 of the Code states:

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

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

15 "(b) Gross negligence.

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

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

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

28 "(d) Incompetence.



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

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

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

8  
9 FIRST CAUSE FOR DISCIPLINE

10 Gross Negligence (Patient E.S.)

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

14 7. E.S. was first seen by Respondent, a pediatrician, on or about December 5,  
15 2001, approximately two days after she was born. Respondent knew this patient's mother  
16 personally, and was aware that the mother was HIV positive. Respondent also was aware that the  
17 mother was breast feeding E.S. At no time did Respondent acknowledge or document in the  
18 medical record any consideration of E.S. or her mother's HIV status.

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

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

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

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

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

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

1 month visit, was not performed and no refusal to undergo this testing was documented.  
2 Immunizations were refused by the parents. The patient's height and weight were recorded at  
3 50<sup>th</sup> and 25<sup>th</sup> percentile respectively.

4 14. The patient returned for a checkup at approximately 21 months of age, on  
5 or about September 5, 2003. Her height was recorded at 60<sup>th</sup> percentile, but her weight has fallen  
6 below the 5<sup>th</sup> percentile for her age, at 20 pounds 5 ounces. Her temperature was 100.

7 Respondent failed to obtain and/or record any information in regard to the patient's diet or  
8 further investigate the patient's limited weight gain. Respondent took no history, did not obtain  
9 and/or record developmental milestones, or address the patient's elevated temperature.

10 Respondent wrote in the medical record that the patient was healthy and recorded his physical  
11 examination only as "normal P.E." with no further details. His diagnosis was "WCC," well child  
12 checkup.

13 15. The patient returned to see Respondent again at approximately 26 months  
14 of age, on or about February 2, 2004. Respondent documented in the medical record that E.S.  
15 was able to walk, talk, that she was "happy" and "playful." The patient's weight, however, was  
16 still below the 5<sup>th</sup> percentile, at 21 pounds 6 ounces. No height measurement was obtained.

17 Respondent documented that in addition to breast feeding, the child ate fruits and vegetables, and  
18 had a "normal P.E." with no further details. Respondent noted that the mother once again  
19 refused immunizations, and he cleared the patient to attend "mother and me" classes. A  
20 hemoglobin test, usually done at 2 years of age, was not performed during this visit, and no  
21 refusal to undergo this testing was documented.

22 16. On January 21, 2005, the patient was seen once again when she was  
23 approximately 3 years and 1 month old. The patient weight was 23.9 pounds and her height was  
24 34.25 inches; both were significantly below the 5<sup>th</sup> percentile. E.S. was being breast fed.

25 Respondent failed to obtain a history or to chart any specific developmental milestones. Despite  
26 a list of foods the child was eating in addition to breast milk, no explanation for her limited  
27 weight gain was considered and/or documented in the medical record. The diagnosis was  
28 "WCC."

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

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

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

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

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

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

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

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

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

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

6  
7 SECOND CAUSE FOR DISCIPLINE

8 (Gross Negligence (Patient Z.L.))

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

12 21. Z.L., a four-year-old boy, was first seen by Respondent on or about May  
13 17, 2004, for a "second opinion consult" of "treatment options." Respondent was told by the  
14 parents that Z.L.'s mother and Z.L. were HIV positive and that he was being treated by a doctor  
15 specializing in HIV at UCSD. Respondent failed to document this fact in the patient's record.  
16 The patient's weight was 30 pounds, 8 ounces, and his height was 37.5 inches. Both were below  
17 the 5<sup>th</sup> percentile for the patient's age. At the time of the visit the patient had an oral temperature  
18 of 102.6. Pulse oximeter reading was 96 and pulse 154. Blood pressure and growth plots were  
19 not done. No past history nor history of allergies, no history of the present febrile illness and no  
20 mention of any physician following this patient in the past was taken and/or recorded in the  
21 medical record. No physical exam was performed. Respondent was given a number of previous  
22 laboratory tests, as well as chest CT scan and an X-ray report, by the parents. The laboratory  
23 tests indicated that Z.L. suffered from a severely depressed immune system. The CT scan and X-  
24 ray reports indicated that "extensive, innumerable bilateral small pulmonary nodules" were  
25 present. The laboratory and x-ray reports were placed in Z.L.'s medical record, but no history  
26 regarding these documents was taken and/or recorded in the patient's chart. Respondent did not  
27 recall seeing these tests. The patient was not examined or treated during this visit. Respondent's  
28 records indicate that the Z.L. was recommended bath and Advil during this visit, and Advil was

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

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

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

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

1 ordered was made in the patient's record.

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

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

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

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

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

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

1 and/or document a physical examination of the patient.

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

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

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

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

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

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

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

18  
19 THIRD CAUSE FOR DISCIPLINE

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

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

24 28. Allegations of paragraphs 6 through 26 are incorporated herein by  
25 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

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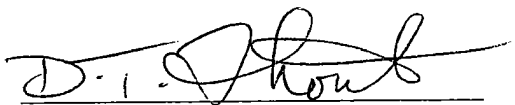
A28858, issued to Paul Fleiss, M.D.;

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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