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. ) File No. 17-2005-169843
) )
) Physician's and Surgeon's )
) Certificate No. A28858 )
) Respondent. )
)

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.


MEDICAL BOARD OF CALIFORNIA

By: [Signature]
Cesar A. Aristeiguieta, M.D., F.A.C.E.P.
Chair
Panel A
Division of Medical Quality
BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Case No. 17-2005-169843
PAUL FLEISS, M.D. OAH No. L2006100478
1824 Hillhurst Avenue
Los Angeles, CA 90027
Physician's and Surgeon's Certificate No. STIPULATED SETTLEMENT AND
A28858 DISCIPLINARY ORDER

PARTIES

David T. Thornton (Complainant) is the Executive Director of the Medical
Board of California. He brought this action solely in his official capacity and is represented in
this matter by Edmund G. Brown Jr., Attorney General of the State of California, by E. A. Jones
III, Deputy Attorney General.
2. Respondent Paul Fleiss, M.D. (respondent) is represented in this proceeding by attorney Gary Wittenberg, whose address is Baranov & Wittenberg, LLP, 2049 Century Park East, Suite 2250, Los Angeles, CA 90067.

3. On or about March 21, 1975, the Medical Board of California issued Physician's and Surgeon's Certificate No. A28858 to . The certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 17-2005-169843 and will expire on September 30, 2007, unless renewed.

**JURISDICTION**

4. Accusation No. 17-2005-169843 was filed before the Division and is currently pending against . A true and correct copy of the Accusation and all other statutorily required documents were properly served on on September 13, 2006. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 17-2005-169843 is attached as exhibit A and incorporated herein by reference as if fully set forth herein.

**ADVISEMENT AND WAIVERS**

5. Respondent has carefully read, discussed with counsel, and fully understands the charges and allegations in Accusation No. 17-2005-169843. Respondent has also carefully read, discussed with counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.
CULPABILITY

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

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

CIRCUMSTANCES IN MITIGATION

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

RESERVATION

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

CONTINGENCY

12. This stipulation shall be subject to approval by the Division. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Division regarding this stipulation and settlement, without notice to or participation by his counsel. By signing the stipulation, understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Division considers and acts upon it. If the Division fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or
effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Division shall not be disqualified from further action by having considered this matter.

OTHER MATTERS

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

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

DISCIPLINARY ORDER

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

1. EDUCATION COURSE Within 60 calendar 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 educational program(s) or course(s) which shall not be less than 15 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge as noted in the accusation and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of 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 40 hours of continuing medical education for each year of probation of which 15 hours were in satisfaction of this condition.

2. MEDICAL RECORD KEEPING COURSE Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping,
at respondent’s expense, approved in advance by the Division or its designee. Failure to
successfully complete the course during the first 6 months of probation is a violation of
probation.

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

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

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

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

Within 60 calendar days of the effective date of this Decision, and continuing
throughout probation, respondent’s practice shall be monitored on a quarterly basis by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours, and shall retain the records for the entire term of probation.

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

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

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

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

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.
4. **NOTIFICATION** Prior to engaging in the practice of medicine, the respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days.

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

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

6. **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.

7. **QUARTERLY DECLARATIONS** 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. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

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

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.
Respondent shall immediately inform the Division, or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

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

10. RESIDING OR PRACTICING OUT-OF-STATE. In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar 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 outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws and Probation Unit Compliance.

Respondent’s license shall be automatically cancelled if respondent’s periods of temporary or permanent residence or practice outside California total two years. However, respondent’s license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.
11. **FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT**

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar 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 which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

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

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

13. **VIOLATION OF PROBATION** Failure to fully comply with any term or condition of probation is a 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, Petition to Revoke Probation, or an Interim Suspension Order 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.

14. **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 request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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

ACCEPTANCE

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

DATED: 07/12/2007

[Signature]

PAUL FLEISS, M.D.
Respondent
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: 7-6-07

GARY WITTEMENGB
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
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: ____________________.

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
Exhibit A
Accusation No. 17-2005-169843
BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

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

Physician's and Surgeon's Certificate No. A28858

Respondent.

Complainant alleges:

PARTIES

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

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

JURISDICTION

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

4. Section 2234 of the Code states:

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

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

(b) Gross negligence.

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

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

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

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

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

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

FIRST CAUSE FOR DISCIPLINE

Gross Negligence (Patient E.S.)

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

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

8. On or about December 5, 2001, or at any subsequent time during which E.S. was Respondent's patient, Respondent did not record in the patient's history known information of the mother's HIV status. Respondent did not take steps to have E.S. undergo HIV testing, and/or failed to make a record of the parents' refusal to undergo such testing. Even though HIV may be transmitted through the breast milk of an HIV positive mother, Respondent failed to advise and/or document that he did advise the mother to discontinue breast feeding until E.S.'s HIV status could be determined. Respondent failed to offer and/or document that he offered to treat E.S. with antiviral therapy to minimize the possibility of HIV being transmitted through breast milk. In fact, the mother breast fed E.S. for three years, with Respondent's knowledge and approval.
9. On or about December 5, 2001, a newborn hearing screening test that was performed at Respondent's office was abnormal in the left ear, but Respondent made no comment in regard to this test result in the medical record and took no steps to evaluate or treat it.

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

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

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

13. On December 3, 2002, Respondent saw E.S. for a well-baby visit at approximately 12 months of age. Once again, Respondent took no history and failed to obtain and/or record the patient's developmental milestones. The physical examination was recorded only as "normal P.E." with no further details. A blood test for anemia, normally done at the 9
month visit, was not performed and no refusal to undergo this testing was documented.

Immunizations were refused by the parents. The patient's height and weight were recorded at
50th and 25th percentile respectively.

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

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

16. On January 21, 2005, the patient was seen once again when she was
approximately 3 years and 1 month old. The patient weight was 23.9 pounds and her height was
34.25 inches; both were significantly below the 5th percentile. E.S. was being breast fed.
Respondent failed to obtain a history or to chart any specific developmental milestones. Despite
a list of foods the child was eating in addition to breast milk, no explanation for her limited
weight gain was considered and/or documented in the medical record. The diagnosis was
"WCC."
17. E.S. was seen for the last time on or about April 30, 2005. Respondent did not examine the patient, although he approved the treatment performed by his nurse practitioner, and co-signed the chart. The chart was documented with an intermittent history of fever and a "raspy cough." It was documented that the child "seems to have rapid, shallow breathing." E.S. was diagnosed with bilateral otitis media and bronchitis. Amoxicillin was given to the parents, although no dosage is indicated in the record. The record indicates that the parents refused to give Amoxicillin at this time. The parents were advised to increase fluid intake, honey and lemon, and to use eucalyptus as needed. The parents were instructed to monitor the child for signs of infection and respiratory distress, and to telephone Respondent or go to the Emergency Room if there was an increase in the symptoms. Respondent observed the patient after the visit with the nurse practitioner and stated that E.S. was acting normally.

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

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

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

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

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

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

E. Throughout the course of E.S., Respondent failed to address E.S.'s failure to thrive.
F. On or about April 30, 2005, Respondent approved of treatment which
failed to conduct an adequate diagnostic work-up, and failed to obtain a chest x-ray.

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

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence (Patient Z.L.))

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

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

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

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

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

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

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

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

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

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

D. During the time Respondent cared for Z.L., Respondent failed to perform
and/or document a physical examination of the patient.

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

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

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

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

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

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

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

THIRD CAUSE FOR DISCIPLINE

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

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

28. Allegations of paragraphs 6 through 26 are incorporated herein by reference.
FOURTH CAUSE FOR DISCIPLINE

(Incompetence – all patients)

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

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

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

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

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

DISCIPLINE CONSIDERATIONS

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

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number
A28858, issued to Paul Fleiss, M.D.;

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

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

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

DATED: September 13, 2006

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