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

In the Matter of the Accusation Against: **ALAN SCHWARTZ, M.D.** 25121 Via Von Batsch Moreno Valley, California, 92557 Physician's and Surgeon's Certificate No. G 18347 Respondent.	Case No. 09-96-69628 OAH No. L-1997120164

MEDICAL BOARD OF CALIFORNIA
I do hereby certify that this document is a true and correct copy of the original on file in this office.
Signature
Title
Date 10-15-04

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Medical Board of California, Division of Medical Quality, as its decision in the above-entitled matter, except that, pursuant to the provisions of Government Code Section 11517(b) and Business and Professions Code Section 2335, the proposed penalty is reduced as follows:

ORDER

Certificate No. G 18347 issued to respondent Alan Schwartz, M.D. is revoked. The revocation is stayed and respondent is placed on probation for ten (10) years upon the following terms and conditions:

1. As part of probation, respondent is suspended from the practice of medicine for sixty (60) days beginning the sixteenth (16th) day after the effective date of this decision.

2. Within thirty days of the effective date of this decision, and on a periodic basis thereafter as may be required by the Division or its designee, respondent shall undergo a psychiatric evaluation (and psychological testing, if deemed necessary) by a Division-appointed psychiatrist, who

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shall furnish an evaluation report to the Division or its designee. The respondent shall pay the cost of the psychiatric evaluation.

If respondent is required by the Division or its designee to undergo psychiatric treatment, respondent shall within thirty (30) days of the requirement notice submit to the Division for its prior approval the name and qualifications of a psychiatrist of respondent's choice. Respondent shall undergo and continue psychiatric treatment until further notice from the Division or its designee. Respondent shall have the treating psychiatrist submit quarterly status reports to the Division or its designee indicating whether the respondent is capable of practicing medicine safely.

Respondent shall not engage in the practice of medicine until notified by the Division or its designee of its determination that respondent is mentally fit to practice safely.

3. Within sixty (60) days of the effective date of this decision, respondent shall submit to the Division or its designee for its prior approval the name and qualifications of a psychotherapist of respondent's choice. Upon approval, respondent shall undergo and continue treatment until the Division or its designee deems that no further psychotherapy is necessary. Respondent shall have the treating psychotherapist submit quarterly status reports to the Division or its designee. The Division or its designee may require respondent to undergo psychiatric evaluations by a Division-appointed psychiatrist. The respondent shall pay the cost of therapy and evaluations.

4. Within sixty (60) days of the effective date of this decision, respondent shall enroll in a course in Ethics approved in advance by the Division or its designee, and shall successfully complete the course during the first year of probation.

5. Respondent is hereby ordered to reimburse the Division the amount of $15,254.78 within ninety (90) days from the effective date of this decision for its investigative and prosecution costs. Failure to reimburse the Division's cost of its investigation and prosecution shall constitute a violation of this order, unless the Division agrees in writing to payment by an installment plan because of financial hardship. The filing of bankruptcy by the respondent shall not relieve him of his responsibility to reimburse the Division for it costs.

6. During probation, respondent shall have a third (3rd) party present while examining minor male patients. Respondent shall, within thirty (30) days of

the effective date of the decision, submit to the Division or its designee for its approval name(s) of persons who will act as the third party present. The respondent shall execute a release authorizing the third party present to divulge any information that the Division may request during interviews by the probation monitor on a periodic basis.

7. Within ninety (90) days of the effective date of this decision, and on an annual basis thereafter, respondent shall submit to the Division or its designee for its prior approval an educational program or course in patient record-keeping, which shall not be less than forty (40) hours per year, for each year of probation. This program shall be in addition to the Continuing Medical Education requirements for re-licensure. Following the completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for sixty-five (65) hours of continuing medical education of which forty (40) hours were in satisfaction of this condition and were approved in advance by the Division or its designee.

8. Within thirty (30) days of the effective date of this decision, respondent shall submit to the Division or its designee for its prior approval a plan of practice in which respondent's practice shall be monitored by another physician in respondent's field of practice, who shall provide periodic reports to the Division or its designee.

   If the monitor resigns or is no longer available, respondent shall, within 15 days, move to have a new monitor appointed, through nomination by respondent and approved by the Division or its designee.

9. 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.

10. Respondent shall submit quarterly declarations under penalty or perjury on forms provided by the Division, stating whether there has been compliance with all conditions of probation.

11. Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of his addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record.

Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last more than thirty (30) days.

12. Respondent shall pay the costs associated with probation monitoring each and every year of probation. Such costs shall be payable to the Division at the end of each fiscal year. Failure to pay such costs shall be considered a violation of probation.

13. Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon requests at various intervals and with reasonable notice.

14. In the event respondent should leave California to reside or to practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the Division or its designee in writing within ten (10) days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty (30) days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Divisions or its designee shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside of California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary period.

15. Upon successful completion of probation, respondent's certificate shall be fully restored.

16. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

17. Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his certificate to the Board. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable

under the circumstances. Upon formal acceptance of the tendered license, respondent will no longer be subject to the terms and conditions of probation.

This decision shall become effective on the 4th day of January, 1999.

IT IS SO ORDERED THIS 2nd day of December, 1998.

CAROLE HURVITZ, M.D.
Chair, Panel B
Division of Medical Quality

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PROPOSED DECISION

On August 3, 4, 5, 6, 7, 17, 18, 19, 1998, in Riverside, California, and on September 1, 1998, in San Diego, California, Stephen E. Hjelt, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter.

Barry Ladendorf, Deputy Attorney General, represented the complainant Medical Board of California.

John Mulvana, Attorney at Law, represented Alan Schwartz, M.D.

Exhibits C and D were received in evidence. They are portions of the appointment logs from the Riverside Medical Clinic and contain privileged information (i.e., the names of other patients who are not part of this proceeding). Because their evidentiary value is slight and the parties agreed, these two documents will be sealed. Evidence was received, the record was closed and the matter was submitted for decision on September 1, 1998.

FINDINGS OF FACT

1. The Accusatory pleadings were all filed by Ronald Joseph in his official capacity as the Executive Director of the Medical Board of California, and not otherwise. During trial, a second amended accusation was filed and served. It did not allege new matter and was not objected to.

2. Respondent Alan Schwartz, M.D., is a physician licensed to practice medicine in the state of California. He was first licensed by the Board on or about May 21, 1970 when the Board issued Physician's and Surgeon's Certificate No. G18347 to him.

Respondent's license has never, previously, been the subject of Board discipline. However, his license has been suspended and currently remains suspended as a result of an Interim Order of Suspension (IOS) entered by a judge of the Office of Administrative Hearings on November 19, 1997.

3. The Medical Board of California seeks to discipline respondent's license on the basis of serious allegations of misconduct with three patients. The most serious allegation involves sexual misconduct which is charged as a component of his treatment of each patient. In addition, there are quality of care claims that respondent's actual medical care fell below the standard of care. There are also charges of failure to secure an informed consent and failure to adequately document the patients' charts. The Board also sought an award of costs pursuant to Business and Professions Code section 125.3.

The substance of the charges relating to patient CW were sustained. These related to the charge of sexual misconduct and to inadequacy of record keeping. Both of these charges represented egregious violations of the standard of care, and for the reasons stated below, justify the extreme sanction of license revocation. However, the quality of care issues regarding patient CW were not established. There was nothing wrong with the workup, the diagnosis or treatment of the patient.

The charges relating to patient's MM and DC were not established by clear and convincing evidence.

Like most of these cases, the ultimate findings rest on findings regarding credibility as well as findings regarding the quality of the expert testimony. The ultimate findings are also made against a backdrop of contemporary social views regarding sexual abuse and misconduct.

4. Patient CW was, in May, 1995, a fifteen year old male who respondent saw and treated for growth and pubertal delay and associated problems. Respondent took a history, examined him, made a provisional diagnosis of delayed puberty, confirmed it with a wrist bone age x-ray and treated the condition with depo testosterone injections. Respondent's care and treatment of this patient was all within the standard of care until October 7, 1996. On that date, in his treatment of the patient, respondent engaged in behaviors that were completely beyond the bounds of medical ethics. He stimulated the young boy's penis to erection which resulted in an ejaculation. He told the young boy that he needed a semen sample to make sure everything was working properly.

Respondent's conduct was also below the standard of care with respect to his record keeping in this case. Not only did he fail to record what he did in stimulating the boy's penis to erection, he also failed to record significant information in the chart regarding an extensive discussion he had with the boy's father at the outset of treatment. Further, he failed to document a physical examination he claims he performed on the same date. There is no question that he had such a conversation. Both he and the boy's father testified to it. In this conversation (out of the presence of the minor) the father gave respondent important information about the boy as well as essential information about the family history of late maturation.

Pediatricians specialize in the care and treatment of young people from birth until age 18. It is a fascinating specialty that presides over the developmental milestones from birth to early adulthood. The speed and complexity of change reaches its highpoint during the adolescent or teen years. It is a tumultuous time and demands special skill and understanding from a doctor.

CW was 15 when he was brought to respondent for treatment. Despite being chronologically in the middle of his teen years, he had failed to start puberty and this was making his life, and that of his family, a living hell. According to his mother he had started the terrible two's and never left them. He was an unpleasant little tyrant who was acted out at home and at school. He was punishing everyone for his short stature.

CW was also obsessed with his lack of growth and development. He had not begun puberty and was markedly smaller than his peers. Also, he had not begun to show any development of his secondary sex characteristics. His penis and testes had not developed at all; he had no pubic or facial hair. He was the butte of jokes and teasing. It is fair to say that his life, as well as his family, was hell.

When CW and his dad went to see respondent on May 3, 1995 it was with the hope of finding some answers to his delayed development. He was 15 years old and was 5 feet 1/2inch and 88 pounds. He was depressed, acknowledged he didn't get along well with others at home or at school. He couldn't sleep. He was in continuation school, cutting class regularly and already had a scrape with the law.

Respondent got additional information about CW and the family from a confidential meeting with the father just before he examined CW. The father confirmed that CW was very defensive about his body and lack of stature and had refused to allow a prior pediatrician to do a hernia exam. The father also gave respondent information on his and his other children's history of late pubertal development. Using this information along with the entire chart from the Riverside Medical Clinic (CW had been a patient most of his life) and his examination, respondent felt that the most likely cause was delayed puberty. To confirm this further, he ordered a wrist bone age x-ray. The result of the radiograph was that the patient's bone age was calculated at 13 years and his chronological age was 15 years 5 months.

Armed with this information, respondent discussed the options. He made it clear that Cw would no doubt start puberty soon, that there was a family history of delayed development and that eventually he would grow to normal height. He also discussed depo testosterone shots with them and their use in jump-starting puberty. Respondent did not fail in his obligation to get the informed consent of his patient. This was a well recognized procedure with no significant risk associated with it. At high doses of depo testosterone, there was a possibility that the epiphyseal growth plates could close prematurely. However, at low doses there was no such risk.

There is no question that the best approach to delayed puberty is watchful waiting. However, when there are psychosocial issues involved, there is a good reason to use depo testosterone. CW presented with the classic case for the use of depo testosterone. His life was hell and he needed this help. Respondent recommended a course of monthly injections for a maximum of 6 months. The first injection was 50 mg. and was given on August 30, 1995. The second injection was given on October 4, 1995 and was 100 mgs. His plan was to recheck in one month.

CW was to receive his next depo testosterone shot on November 3, 1995 but he left the office without being seen. He was next seen by respondent on May 2, 1996 at which time it was noted that CW was in the middle of his pubertal growth spurt. He was 5 feet 4 ½ inches and weighed 105 pounds. This May 2, 1996 appointment was complaint specific for a fever and cough only. On May 8, 1996 respondent saw CW again this time for complaints of pain in his left knee off and on for the last 3 years. Respondent performed an examination with x ray and referred CW for an orthopedic consult.

He next saw CW on October 7, 1996, once again for problems with his knee. CW was 16 years 10 months and was 5 foot 6 inches and weighed 114 lbs. After examining his knee, respondent and CW discussed his pubertal development. CW clearly had responded to the stimulus of the depo testosterone shots. However, he was still very concerned with what he perceived as his small and under developed genitals. Respondent told him that it was obvious from looking that his penis and testicles had grown and that a flaccid penis was not a reliable measure of its length. He told CW that the only objective way to measure a penis was at its full erect measure and asked if he wanted to do this. The patient nodded his head yes.

Respondent took CW's penis which was semi erect and proceeded to massage it with his ungloved hand until it was erect. He then took a ruler and measured it at just under 4 inches in length. He asked CW if he could ejaculate and CW said yes. He continue to stimulate the penis saying that he needed a semen sample to determine that everything was working properly. CW ejaculated and respondent wiped the ejaculate off with gauze.

CW was confused and uncertain about what had just happened. Within a few days he spoke with his best friend and he decided to tell his parents. Rather than speak face to face, he wrote his dad a note, which he did often when he was too

embarrassed to talk about something. The note, (exhibit 3 in evidence) reads in relevant part as follows:

> "...When I went to see Doctor Schwertz (sic) the last time he told me how big I would be and how old my body was. He also took my penis measurements, and he wanted a sample of my seimen (sic) so he ejackulated (sic) me until I well you know butt (sic), I didn't say anything because I was confused and I thought it was procedure. But now that I think about it, if he needed a sample wy (sic) didn't he say to go in the bathroom and do it my self."

It was established by competent and convincing expert testimony that respondent's actions in stimulating CW's penis and ejaculating him were extreme departures from the standard of care and that there was no medical indication for these acts. There had been a medical indication for measuring the penis but certainly not in an erect state. Although there are some occasions in medical practice where a semen sample might be necessary, there was absolutely no medical indication for such an act here.

The defenses raised that CW misperceived the events and that he did not ejaculate are not persuasive. Furthermore, respondent's testimony that he had never ever been faced with such a situation in 27 years of practice as a pediatrician is unpersuasive. There is no question that physicians are confronted with novel situations often even in their third decade of practice. But to think that respondent even remotely considered that stimulating a young mans penis to erection was an appropriate way to get a penile measure leaves the trier of fact incredulous.

Good doctors occasionally make bad mistakes. That is the nature of the practice of medicine. Sometimes they are flat out wrong. Sometimes they err in judgment. After all, much of what a doctor does is based on hunches and educated guesses. However, bad judgment is at least understandable. What respondent did here is not understandable because he asks us to believe he simply made a good faith mistake in how to go about measuring a male penis. Respondent failed to carry out his basic obligation to this patient. He failed to respect his dignity and his privacy. He breached professional boundaries completely.

What respondent did was a sexualized act even if, by some strange chance, he did not intend to sexually stimulate the boy. He cannot be this clueless. He cannot be so out of touch with issues of fundamental appropriateness when dealing with the examination of the genitals of a teenage boy. To think for one moment that this behavior is somehow simply misguided to stretch credulity beyond its limits. This is the most likely explanation for the failure to document any of this in the chart. Quite simply, none of this was medically defensible and respondent knew it.

5. Patient MM was, in October, 1996, a 12 year-old male, seen by respondent for the purpose of receiving a second opinion regarding leg pains. The parents had taken their son for evaluations of the leg pain and had been assured by the

child's regular doctor, a board certified pediatrician, that there was nothing wrong other than the typical growing pains associated with very active children of this age.

On the day in question, the young patient was with his brother who had an ear infection and his father. The examination took place in a regular exam room with the father present for all activities.

By the time of the exam, the complaint was not just pain in legs, but numbness as well. Dr. Schwartz performed an exam appropriate to the circumstances. There was nothing unusual about his exam other than its thoroughness. He spent the requisite time necessary to check both femoral pulses as well as range of motion. When a patient presents for a second opinion, there is always implicit in the situation a recognition that the patient is not satisfied or comfortable with the first opinion. It is not uncommon for the second physician to be more thorough in his examination in order to give reassurance to the patient that the patient's concerns are being taken seriously.

The claim here is that Dr. Schwartz, when he sat down after performing his examination of the patient in front of the boy's father, had an erection which showed as a bulge in his pants. It was not established to clear and convincing certainty that respondent did anything unprofessional in his examination of this patient. Nor was it established that he had an erection after this examination. It is as likely as not that what the father saw was respondent's wallet and pen light which he typically carried in his front pocket. Respondent did not, customarily, wear a coat.

6. Patient D.C. was, in October, 1995, a 10 year-old male seen by respondent for evaluation for attention deficit disorder with hyperactivity (ADHD). Respondent saw this developmentally disabled boy on approximately five occasions. At each visit the patient was accompanied by his mother and her sister. On one occasion, the young boy's uncle was present. There was nothing unprofessional about the examination, treatment or advice given by respondent at any time during his care and treatment of this boy.

After the stories about respondent hit the local paper, and over a year after respondent last saw the boy, Phyllis Crosswhite contacted the medical board and told them about some suspicious conduct respondent engaged in while he treated her son. This conduct related to the issue of therapeutic touch and massage and its use on children with ADD and/or a history of being sexually abused. What her testimony became was a self fulfilling prophecy that began with her displeasure at respondent for not doing allergy testing on her son. Over time it morphed into repeated acts of obvious sexual abuse taking place in front of mom and her sister under the guise of advice and treatment.

Phyllis Crosswhite was not a credible witness. This is not to say that she lied nor is there any thing to suggest that she was not motivated by her care and concern for her son in testifying. She was not a good or accurate historian of the facts. She was well aware that her son had been sexually molested by the boy's father and made

respondent aware of this fact as well. She is, with good reason, hypervigilant to protect her son. She is also well aware of what appropriate touching is. If there had been one real episode of sexual misconduct in that room, she would have spoken immediately.

What this particular claim is about is the hysteria that is the unfortunate by-product of sexual abuse claims. People read these claims and reinterpret ambiguous events from the past in a way to conform to what appears to be authoritative evidence of present wrongdoing. Couple with that the fact that respondent did not do what she wanted him to do in terms of allergy testing and you have a perfect situation for this type of claim.

Somehow, the claim seems to be that respondent used massage therapy as a cover for his secret desire to touch this boy sexually. There is no good and credible evidence to support this. Respondent demonstrated a simple massage technique to the mother and suggested that she use it on her son at home. The basis of this is one of the simplest and most obvious truths about humans-touch is pleasurable and soothing. What he related to her was that he was aware of professional literature that suggested that touch and massage could be beneficial for children with ADD or who had been sexually abused. He demonstrated this to her. He did not massage the boy's penis or testicles nor did he suggest that she do that.

Respondent did, on at least one occasion, examine and touch the young child's genitalia. This was in response to a claim by the mother that her son was exhibiting the signs of precocious puberty, i.e. pubic hair and facial hair. Respondent examined DC and found no evidence of the facial and pubic hair that the mother believed was there.

Therapeutic touch is a can of worms that distracted from the proper focus of this case. Efficacy studies to determine safety and effectiveness of therapeutic touch are beyond the capacity and the mission of this particular proceeding. In fact there is a very real difficulty definitionally with the term itself. The notion that we are dealing with here is not about therapeutic touch and claims by partisans that it is a specific healing practice based on the use of the hands of a practitioner to direct energy fields to identify and treat illness. This is not what the issue is about in this case.

This case deals simply with the question whether it was within or outside the standard of care for respondent to suggest and recommend massage to help a patient suffering from ADD or with a history of sexual abuse. Although the specific literature discussed by the experts was not made part of the record, it is clear that human touch is soothing and relaxing and in some sense very healing. It ameliorates distress and can be very calming and relaxing. To suggest that this might be used on a patient with the diagnoses that DC had is certainly not outside the standard of care. Nowhere is there a suggestion by respondent that this somehow is a cure for whatever ails DC, only that it might be soothing.

7. CHARTING AND RECORD KEEPING

Respondent's record keeping and charting was appalling and represented an extreme departure from the standard of care. It is rare for record keeping and charting to be a large issue in a case like this. Charting is an ever present issue for all doctors who work in a busy clinical setting. There is never enough time, always too much to deal with before the next patient is seen. Respondent's counsel very aptly stated in closing argument that he had never seen a chart note that he could not make some hay with due to some inadequacy.

Unfortunately, respondent's errors in charting are serious because they involve numerous failures to enter important information in a patient's chart and the doctor's explanation for these failures does not have the ring of truth.

Perhaps these chart notes are the face of the future of medicine under managed care. The Riverside Medical Clinic is a managed care practice where at least 80% is capitated. There can always be some quibble with the issue of adequacy but in the case of respondent's charting, it was either non-existent, incomprehensible or illegible. During his testimony there were occasions where he could not even decipher his own handwriting. Some of it appears to be a style adopted by this clinic and carried to an extreme by respondent. To reduce the amount of time they spend writing they developed abbreviations for their abbreviations. Respondent acknowledged that he, on occasion, would forget to enter things in his chart. Even good doctors sometime forget to make complete and accurate records, It is for this reason that the question of the adequacy of charting should not be based solely on an isolated event or entry. The totality of the record keeping is the more appropriate standard for review.

Based on the totality of respondent's record keeping and charting, they are grossly deficient. The failure to chart important findings and information is not isolated. His deficiencies are serious in this regard. Respondent failed to appreciate the simple truth that chart notes exist to further the skillful treatment of the patient. They are kept to record what the physician observes and deduces. They are kept to record data and to describe and record the process of active diagnosis. They are kept because even with the best memory, a doctor cannot be expected to remember all that is important about a patient in the past. Even if a doctor had a photographic memory, he would still be required to accurately chart. It is common for patients to be seen by many physicians over their life times. Patients move, change health care plans; doctors retire and die. It is to be expected that a new doctor would need a historical referent for a new patient. It is not reasonable to expect that a patient could give a new doctor all necessary information about a past illness or course of treatment. This information may be exceedingly important. This information will be available and accessible if a doctor simply does his job and keeps accurate chart notes. Respondent failed to do this. His charting was neither adequate nor accurate

8. It was established that complainant incurred actual and reasonable cost for investigation and prosecution in the amount of $15,254.78.

9. All the experts who testified in this case were well qualified to render expert opinions. They were all of assistance to the trier of fact. Dr Carella testified that respondent's quality of care was substandard especially with respect to his treatment of CW. Unfortunately the factual universe he relied on was inadequate for his opinions on quality of care to be persuasive. Furthermore, his opinions about what is required of a reasonably competent pediatrician to work up, diagnose and treat a case of delayed puberty was not persuasive, particularly in light of the strongly persuasive testimony of Dr. Cortez.

What all the experts agreed upon is that you do not measure a teenage boy's penis in an erect state. What they disagreed on was what respondent's actions meant, i.e. whether there was sexual misconduct or whether this was just a regular doctor confronted by a novel situation who simply made an error in judgment that was understandable because pediatricians are not taught to properly measure penises as part of their training. This was not a simple error in judgment. It was a man stimulating a boy's penis to the point of ejaculation and telling him he needed a semen sample to check that things are working.

10. Respondent has been practicing as a pediatrician for over 28 years. For the last 10 years he has been a pediatrician at the Riverside Medical Clinic. He has specialized within the clinic in the areas of nutrition, allergies and ADD. He believes in being a holistic practitioner taking care of the emotional needs of his patients as well as their physical ones. He did not go into medicine to make money but rather to help others.

Before his license was suspended he was elected unanimously by the 16 pediatricians at the Riverside Medical Clinic to be the chairman of their pediatric department. After the Interim Suspension Order was issued he was allowed to practice with restrictions, but he took a leave of absence after newspaper articles were published about the allegations. He is very depressed and feels that he was tried and convicted by the press long before this trial took place.

Respondent testified that in all his years as a pediatrician, he had never ever measured a penis before. According to respondent, he did this to reassure the young boy that he was in fact growing. He feels that he explained what he was going to do and that the patient assented. After he measured the penis and returned the ruler to the drawer, he was "stunned" to see a drop of fluid on the penis and drops on the boy's abdomen. He denies ever intending to get a semen sample or telling the patient that is what he wanted to do. When he saw the fluid, he was shocked and embarrassed and tried to make the best of an awkward situation, Afterwards, he came to feel that he had incorrectly measured the patient's penis. He looked in a pediatric endocrinology text and at a chart that one of his colleagues had. He acknowledges that he made a mistake in

measuring the penis in an erect state but he did it that way because, at that moment, it made sense to him.

Civil litigation was filed by CW against respondent. The case has been settled and the necessary filing has been made to the Medical Board.

DETERMINATION OF ISSUES

1. Jurisdiction over the practice of medicine is vested in the Medical Board of California by virtue of the provisions of the Medical Practice Act, Business and Professions Code section 2000 et seq. Section 2004 establishes the Division of Medical Quality which has responsibility for the enforcement of the disciplinary provisions of the Medical Practice Act.

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

3. Business and Professions Code section 2234 provides that unprofessional conduct includes, but is not limited to, the following:

> " (a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.
> " (b) Gross negligence.
> " (c) Repeated negligent acts.
> " (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.

4. Business and Professions Code section 2266 provides, in pertinent part, that:

> "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."

5. Business and Professions Code section 726 provides, in pertinent part, that:

"The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer which is substantially related to the qualifications, functions, or duties of the occupation for which the license was issued constitutes unprofessional conduct and grounds for disciplinary action for the person licensed under this division, under any initiative act referred to in this division and under Chapter 17 (commencing with Section 9000) of Division 3."

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

7. Section 16.01 of the 1996/1997 Budget Act of the State of California provides, in pertinent part, that :

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

8. Cause was established to impose discipline on respondent for violation of Business and Professions Code section 2234 (b) in that he engaged in conduct that constituted and extreme departure from the standard of care, and thus was grossly negligent, by virtue of Finding of Fact 4.

9. Cause was established to impose discipline on respondent for violation of Business and Professions Code section 2234 (in that he engaged in conduct that constituted a departure from the standard of care repeatedly by virtue of Finding of Fact 4.

10. Cause was established to impose discipline on respondent for violation of Business and Professions Code section 726 in that he engaged in sexual misconduct with a patient or patients by virtue of Findings of Fact 4, 9, and 10.

Section 726 reads as follows:

> "Sexual Relations with Patients. The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this division, under any initiative act referred to in this division and under Chapter 17 (commencing with Section 9000) of Division 3.

This section shall not apply to sexual contact between a physician and surgeon and his or her spouse or person in an equivalent domestic relationship when that physician and surgeon provides medical treatment, other than psychotherapeutic treatment, to his or her spouse or person in an equivalent domestic relationship."

11. Cause was established to impose discipline on respondent for violation of Business and Professions Code section 2266 in that he failed to maintain adequate and accurate records relating to medical services rendered to patients by virtue of Findings of Fact 4, 7 and 10.

12. Cause was established to impose discipline on respondent for violation of Business and Professions Code section 2234 in that his conduct constituted general unprofessional conduct, defined as unbecoming a member in good standing in the medical profession by virtue of Findings of Fact 4, 7, 9 and 10.

13. Cause was established to award costs of investigation and enforcement pursuant to Business and Professions Code section 125.3. Complainant established that it incurred actual and reasonable costs in the amount of $15,254.78.

14. The administrative law judge has followed and relied upon California Evidence Code section 720 and BAJI8th 2.40 and 2.41 as well as those facts set forth in the Findings of fact above in determining the persuasiveness of the numerous experts who testified.

BAJI 2.40 reads in relevant part:

> " A witness who has special knowledge, skill, experience, training or education in a particular subject has testified to certain opinions. Any such witness is referred to as an expert witness. In determining what

weight to give any such opinion, you should consider the qualifications and believability of the witness, the facts or materials upon which each opinion is based, and the reasons for each opinion.
An opinion is only as good as the facts and reasons on which it is based. If you find that any such fact has not been proved, or has been disproved, you must consider that in determining the value of the opinion. Likewise, you must consider the strengths and weaknesses of the reasons on which it is based..."

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

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

The BAJI instructions are important tools to be used by the administrative law judge. They were developed and are used in all civil jury trials in California. They are guides for the trier of fact in resolving the contested issues in a lawsuit.

The administrative law judge has multiple functions in a case such as this. One function is to sit on behalf of the Medical Board of California and make findings of fact. As such, the administrative law judge acts in a fashion analogous to a jury and BAJI provides excellent guidance.

15. CREDIBILITY FINDINGS

California Evidence Code section 780 deals with the issue of believability of witnesses. It provides guidance for the trier of fact in determining whether a witness' testimony is credible. It lists a variety of factors that must be assessed in determining credibility. These factors are:

1. The demeanor of the witness while testifying and the manner of testifying;
2. The character of that testimony;
3. The extent of the capacity of the witness to perceive, to recollect, or to communicate any matter about which the witness testified;
4. The opportunity of the witness to perceive any matter about which the witness has testified;
5. The character of the witness for honesty or veracity or their opposites;
6. The existence or non-existence of a bias, interest, or other motive;
7. A statement previously made by the witness that is consistent with the testimony of the witness;

8. A statement made by the witness t6hat is inconsistent with any part of the testimony of the witness;
9. The existence or non existence of any fact testified by the witness;
10. The attitude of the witness toward the action in which testimony has been given by the witness or toward the giving of testimony; and
11. An admission by the witness of untruthfulness.

The credibility findings herein made are further informed and conditioned by reliance on BAJI, 8th. These are formal instructions for the trier of fact to assist in the evaluation of evidence.

BAJI 2.21 reads as follows:

"Discrepancies in a witness's testimony or between such witnesses testimony and that of other witnesses, if there were any, do not necessarily mean that [any] [such] witness should be discredited. Failure of recollection is common. Innocent misrecollection is not uncommon. Two persons witnessing an incident or a transaction often will see or hear it differently. Whether a discrepancy pertains to an important matter or only to something trivial should be considered by you."

BAJI 2.22 states:

" A witness false in one part of his testimony is to be distrusted in others. You may reject the entire testimony of a witness who wilfully has testified falsely on a material point, unless, from all the evidence, you believe that the probability of truth favors his testimony in other particulars."

16. Respondent's act of sexual misconduct with patient C.W. is extremely serious and not just simply an error in judgment. Errors in judgment, even when serious, can often be taken care of with probationary oversight and less than outright revocation of license. Despite his explanation, his actions with this patient were sexual in nature. From his long experience treating adolescents and knowing the background of this particular patient, he was on notice that a breach of his professional obligation to maintain an appropriate boundary with this boy could do nothing but increase his confusion and distress about his sexual identity. The fact that he failed to record any of his actions in the chart only compounds the seriousness of the situation. Respondent is presently unfit to practice medicine. He presents a danger to his patients at present.

He was very thoroughly examined and evaluated and tested by experienced mental health professionals. Not one of them made a diagnosis that he was a pedophile or that he demonstrated pedophilic tendencies.

ORDER

1. Physician's and Surgeon's Certificate number G18347 issued to Alan Schwartz. M.D., is revoked.

2. Respondent shall reimburse the complainant $15,254.78 as and for its actual and reasonable costs of investigation and enforcement.

Dated: September 15, 1998

STEPHEN E. HJELT
Administrative Law Judge
Office of Administrative Hearings