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

In the Matter of the Accusation Against: STEPHEN KAO LIU, M.D. 1552 Coffee Road, Suite 201 Modesto, California 95355 Physician's and Surgeon's Certificate No. A 50939, Respondent.	Case No. 800-2015-014954 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California (Board).

2. On June 30, 1992, the Board issued Physician's and Surgeon's Certificate No. A50939 to Stephen Kao Liu, M.D. (Respondent). That license was in effect at all times relevant to the charges brought herein and will expire on January 31, 2020, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2051 of the Code states:

"The physician's and surgeon's certificate authorizes the holder to use drugs or devices in or upon human beings and to sever or penetrate the tissue of human beings and to use any and all other methods in the treatment of diseases, injuries, deformities, and other physical and mental conditions."

6. Section 2234 of the Code, states:

"The board 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.

"(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.

". . .

"(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.

". . ."

BACKGROUND

7. On or about June 26, 2015, Patient A[1] (Patient) presented to Respondent's outpatient Interventional Radiology Center in Modesto, California for a left lower extremity arteriogram and intervention for a thrombosed left lower extremity bypass graft, originally placed

[1] Patient A is used in lieu of initials in order to protect patient privacy.

in 2007. Patient A had an extensive medical history including a renal transplant, diabetes, right leg amputation, and multiple revascularization procedures, including prior thrombectomies of the left lower extremity graft. Patient A reportedly had pain both at rest and with activity, and had a cold left leg prior to and immediately before the procedure. In order to improve blood flow in Patient A's left leg, Respondent performed an arteriogram, angioplasty, tPA administration, atherectomy, and stent placement within the left lower extremity, including an attempt to revascularize the native superficial femoral artery. Images show an initially thrombosed femoral artery to popliteal bypass graft and deep femoral artery. Further images show balloons inflated in various parts of the graft and native arteries. Final images show flow through a patent common femoral artery (CFA), bypass graft and peroneal and anterior tibial arteries. The deep femoral artery appeared occluded shortly beyond its origin.

8. After the procedure, a nurse noted Patient A's foot was cold. Respondent also assessed Patient A post procedure and found the foot to be cold, both two (2) and four (4) hours post procedure. Respondent recommended to Patient A that she travel to the ER of U.C. Davis, in Davis, California. Patient A was then driven by the companion two hours to U.C. Davis Medical Center ED, where she was assessed by an ED physician and Vascular Surgery. She was taken to the operating room where she underwent surgery which included a left leg, above-the-knee, amputation, and a deep femoral artery thrombectomy.

9. The standard of care for an interventional radiologist when performing an intervention is to recognize complications and to take appropriate steps to manage them. The post procedural period, in this case, was very complex. Although Patient A's foot was reportedly cold and painful immediately post procedure, it can take some time for the foot to warm, and pain could be caused by reperfusion. However, it is clear that two to four hours after the procedure, Respondent recognized that Patient A's leg had not improved, was worsening, and that further care was needed. Thus, when it became clear to Respondent that the foot was not improving, he recommended that Patient A seek more treatment.

10. The records of Respondent's care of this patient are inadequate in that they do not state whether Patient A's clinical status post procedure was worse than before the procedure. A

post procedure pulse examination was lacking which would have helped in determining Patient A's clinical status. Patient A reported to the U.C. Davis ER physician that the pain began after the procedure and steadily worsened, which indicates that Patient A rethrombosed her bypass graft and deep femoral artery (source of collateral flow) immediately. This should have been recognized by Respondent. However, Respondent's documentation for this patient was inadequate and sparse. The medical records lack documentation of the change in Patient A's status post procedure, the discussion with Patient A leading up to the discharge from his center, and Patient A's disposition.

11. Respondent discharged Patient A to her own care directly from his center instead of calling Emergency Medical Services (EMS) which indicates that Respondent failed to recognize the gravity of what was occurring. His conduct did not ensure that Patient A would be attended continuously until definitive treatment was given.

12. Patient A arrived at U.C. Davis ED at approximately 8:00 P.M., two hours after Patient A was discharged from Respondent's center. Had the process of discharge and transfer occurred earlier, it is possible that the outcome could have been different.

13. Respondent failed to communicate with the U.C. Davis ER ahead of Patient A's arrival. Respondent gave Patient A a CD of the procedure, a copy of the medical records, and his phone number, as an attempt of communicating with the U.C. Davis ER personnel regarding the events that occurred at Respondent's center. However, Respondent failed to telephone U.C. Davis to give a verbal report on Patient A and to provide a more informative transition and preparation for continued care. In expecting the practitioners at U.C. Davis to call Respondent to gain more information, Respondent improperly sought to shift his responsibility to provide needed information about Patient A to the staff at U.C. Davis.

14. Respondent failed to maintain documentation regarding the change in Patient's status post procedure, the discussion leading up to the discharge from his center, and Patient A's disposition. He stated that he was not sure if he documented these events; and if he did, he sent them with Patient A, and they were since lost. Documentation of a change in Patient A's clinical status was lacking and was needed for continuity of care. Also, documenting Patient A's

disposition was needed in case questions arose about what precautions to take. Also, the medical records lacked documentation of what was discussed regarding Patient A's disposition, and where she was told to go for further care.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

15. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he was repeatedly negligent in the care and treatment of Patient A. The circumstances are as follows:

A. The facts and circumstances alleged in paragraphs 7 through 14 are incorporated here as if fully set forth.

B. Respondent was repeatedly negligent in his care and treatment of Patient A regarding his overall disposition of Patient A after Respondent correctly identified that a complication occurred and that further care was needed, as follows:

(1) Respondent failed to offer to transport Patient A by ambulance or EMS services to ensure that she would be attended continuously until definitive treatment was given. His failure to do so indicates that he failed to understand the gravity of the situation which was occurring.

(2) Respondent to adequately communicate with the U.C. Davis ER and to call ahead of time to inform them that Patient A was in transit and to inform them of the circumstances.

(3) Respondent failed to maintain adequate and accurate records.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

16. Respondent is subject to disciplinary action under Code sections 2266, in that he failed to maintain adequate and accurate records regarding his treatment and care of Patient A. The circumstances are described above in the First Cause for Discipline are incorporated as if fully set forth.

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DISCIPLINE CONSIDERATIONS

17. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that effective on or about May 6, 2016, in a prior disciplinary action entitled *In the Matter of the Accusation Against Stephen Kao Liu, M.D.* before the Medical Board of California, in Case No. 08-2012-225965, Respondent's license was publicly reprimanded with terms and conditions for repeated acts of negligence, regarding the care provided to patients. That decision is now final and is incorporated by reference as if fully set forth.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 50939, issued to Stephen Kao Liu, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants and advance practice nurses;

3. If placed on probation, ordering him to pay the Medical Board of California the costs of probation monitoring; and,

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

DATED: December 19, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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