

BEFORE THE
RESPIRATORY CARE BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

Case No. R-1969

JOSEPH ERNEST CARRILLO
795 Marlboro Court
Claremont, CA 91711

DECISION AND ORDER

The attached proposed Decision of the Administrative Law Judge is hereby adopted by the Respiratory Care Board of California, Department of Consumer Affairs, as its Decision in the above entitled matter.

This Decision shall become effective on July 19, 2006.

It is so ORDERED July 12, 2006.



LARRY L. RENNER, BS, RRT, RCP, RPFT
PRESIDENT, RESPIRATORY CARE BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

**BEFORE THE
RESPIRATORY CARE BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the Accusation Against:

**JOSEPH ERNEST CARRILLO
795 Marlboro Court
Claremont, California 91711**

**Respiratory Care Practitioner
License No. 18493**

Respondent.

Case No. R-1969

OAH No. L2005080393

PROPOSED DECISION

This matter came on regularly for hearing on March 13, 14, 15, and 16, 2006, and May 15, 2006, in Los Angeles, California, before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California.

Stephanie Nunez (Complainant) was represented by Gloria L. Castro, Deputy Attorney General.

Joseph Ernest Carrillo (Respondent) was represented by Tom M. Allen, Attorney at Law.

During the course of the hearing, Complainant amended the Accusation as follows:

1. At page 1, line 25, "2005" is deleted and replaced by "2007."
2. A fourth cause for discipline is added as paragraph 14, which reads:

Respondent is subject to disciplinary action under section 3750, subdivision (k), in that he made grossly incorrect and grossly inconsistent entries in the patient's record. The facts and circumstances set forth in Paragraph 11 of this Accusation are incorporated herein by this reference.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision.

FACTUAL FINDINGS

The Administrative Law Judge makes the following Factual Findings:

1. Stephanie Nunez made the Accusation in her official capacity as the Executive Officer of the Respiratory Care Board, Department of Consumer Affairs, State of California (Board).

2. On January 5, 1996, the Board issued Respiratory Care Practitioner License No. 18493 to Respondent. The license will expire on September 30, 2007, unless renewed.

Respondent's Background

3. Respondent received his respiratory care training at Loma Linda University, earning his Associate's degree in 1994. He continued his education in the same program working toward a Bachelor of Science degree in respiratory therapy. He discontinued his studies in his senior year but has since returned to them.

4. Respondent is a Registered Respiratory Therapist, a Pediatric Advanced Life Support (PALS) provider, a Neo-Natal Resuscitation Provider, and a life support health care provider with the American Heart Association. He has served as an Advanced Cardiac Life Support (ACLS) instructor for approximately one year.

5. Respondent enjoys an excellent reputation as a respiratory care practitioner and as the Director of two hospital respiratory care departments. His license has never before been subject to discipline.

The Events of November 25, 2003

6. At all relevant times, Respondent was the Respiratory Director at Desert Valley Hospital (DVH) in Victorville, California.

7. On November 9, 2003, Patient O.H.¹, a 65-year-old female, was admitted to DVH suffering from respiratory failure with possible pneumonia. Her medical history included chronic renal failure for which she underwent hemodialysis, diabetes mellitus, and hypertension. She was intubated and admitted to the intensive care unit (ICU). During her hospital course, she was extubated twice but was unable to maintain the airway and was re-intubated. On November 21, 2003, Peter Fischl, M.D. performed a tracheostomy on O.H. and her condition was stabilized.

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¹ The patient's initials are used in lieu of her name in order to protect her privacy and that of her family.

8. On November 25, 2003, at approximately 9:00 a.m., pulmonologist, Rajeev Yelamanchili, M.D., saw O.H. in the ICU. At that time, O.H. was on mechanical ventilation with 34 percent oxygen. Blood gases taken that morning at 7:04 a.m. were all within the acceptable range. ICU staff informed Dr. Yelamanchili that a significant leak existed in the patient's 6.0 tracheostomy tube. Dr. Yelamanchili heard a "gurgling" sound around the tube cuff and confirmed the presence of a leak, but found no significant decrease in the oxygen level. Attempts to expand the cuff to between 30 and 40 cm were unsuccessful.

9. Dr. Yelamanchili informed O.H.'s nurse, Donna Stepanek, that the tube should be changed to an 8.0. Because Dr. Yelamanchili was uncomfortable changing tracheostomy tubes, he wrote an order in O.H.'s chart for the surgeon, Dr. Fischl, to change it. That order read, "Call Dr. Fischl to change trach tube 6 x 8 today." Dr. Yelamanchili did not give any verbal orders regarding O.H. on November 25, 2003.

10. Respiratory care practitioner, Sandra Salas, was on duty that morning and was in the room when Dr. Yelamanchili visited O.H. Ms. Salas then either overheard but misunderstood, or only partially overheard, Dr. Yelamanchili's statements to O.H.'s nurse. In any event, Ms. Salas believed Dr. Yelamanchili wanted the Respiratory Care Department (namely, her) to perform the tracheostomy tube change. She did not feel qualified to perform the tube change, so she approached Respondent, who was her supervisor, and told him that she had a verbal order to perform the change. Respondent was well-experienced in changing tracheostomy tubes. He reassured Ms. Salas that he could do it, and they returned to the ICU together, arriving only a few minutes after Dr. Yelamanchili left the area. Nurse Stepanek told Respondent that she was about to call Dr. Fischl and ask him to change the tracheostomy tube. Respondent told Nurse Stepanek that he could do it and that he had done so many times. Based on that representation, Nurse Stepanek did not call Dr. Fischl, and permitted Respondent to proceed with the tube change.

11. Respondent did not check the patient's chart for either a written order or documentation of a verbal order.

12. At the administrative hearing, Respondent admitted that his failure to check the patient's chart for a verbal or written physician's order before changing the tracheostomy tube had been a mistake. He demonstrated sincere remorse for that error. Respondent was credible in his testimony that he would never have changed the tracheostomy tube had he known that neither a verbal nor a written order had been issued calling for the tube to be changed by a respiratory care practitioner, or that a written order existed calling for the tube change by the surgeon.

13. Respondent went to the patient's bedside. He noted the leak around the tube and some volume loss on the ventilator. He set up the "trach kit," hyperoxygenated the patient, removed the trach ties, removed the 6.0 tube and inserted the 8.0, feeling some mild resistance as he did so. He then inflated the cuff of the new tube, manually ventilated O.H. with an ambu-bag and, using his stethoscope, listened for and heard bilateral breath sounds. He then asked Ms. Salas to confirm the breath sounds, which she did.

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14. Respondent reattached the ventilator, confirmed the proper settings on the machine and began to clean up the area from the procedure. Upon doing so, he heard the ventilator's high pressure alarm sound and saw visual highlighting on the machine that corresponded to the alarm. Almost immediately, O.H. became "dusky" and developed subcutaneous emphysema. Respondent disconnected the tube from the ventilator and manually ventilated O.H. with an ambu-bag, this time experiencing resistance in that process. He looked at the patient's skin color and at the monitor which indicated a decrease in her oxygen saturation. O.H.'s blood pressure decreased and she became bradycardic. A Code Blue was called.² For approximately seven minutes during the code, the patient was without a pulse or blood pressure.

15. An Emergency Department physician responded to the Code Blue. He found "no good breathing sounds" during ambu-bag ventilation. He also noted that the endotracheal tube appeared to be out of the trachea. He changed the tube back to a 6.0. The initial result of the Code Blue was successful, and the Emergency Department physician noted a change O.H.'s color after he placed the 6.0 tube in the trachea. However, O.H. failed to recover from the event. Later that day, she developed cardiac arrhythmia and expired at 1:40 p.m.

16. Dr. Fischl was not informed of Dr. Yelamanchili's order until some time after the Code Blue was over. Upon learning of the order, he indicated that he would not have changed the tracheostomy tube because the tracheostomy was not yet mature enough to do so.

17. In a report dictated on November 26, 2003, Dr. Fischl wrote: "[T]he patient's arrest was followed by massive development of subcutaneous emphysema, which is secondary to insufflation of air through subcutaneous tissues directly. There is no evidence of postoperative pneumothorax." However, in a "final" report of a chest x-ray taken approximately 25 minutes after the Code Blue was called, Larry Owens, M.D. found that O.H. had developed a 50 percent tension pneumothorax on the right side as compared to an x-ray taken at 6:40 a.m. the same day.

18. Respondent wrote a chart note following the event. Although he described most of what had occurred, he failed to note that the patient had suffered subcutaneous emphysema or that a Code Blue had been called.

19. As of November 25, 2003, DVH had in effect a policy regarding the circumstances under which a respiratory care practitioner could change a tracheostomy tube, and the procedures to be followed when doing so. The policy read, in part:

Respiratory Care Practitioners may upon a physician[']s order, change patient tracheostomy tubes.

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² The identity of the individual who called the Code Blue was not established by the evidence.

20. Following the incident, Respondent served on a team that revised the hospital's policy.³ The revision went into effect in January, 1994. It read in pertinent part:

Desert Valley Hospital Respiratory Care Practitioners may upon a physician[']s order, change patient tracheostomy tubes.

1. The initial trach change will be done by an ENT or Designated (*sic*) physician.
2. RTs will not change a patient[']s trach tube to a larger size, this (*sic*) shall be performed done (*sic*) by a physician.

The Experts

21. Complainant's expert witness was Michael Werner, a Registered Respiratory Therapist, presently the Director of Clinical Support Services at Western Medical Center in Santa Ana, and formerly the Administrative Director at Hollywood Presbyterian Medical Center in Los Angeles. Respondent offered the expert testimony of William P. Klein, M.D., the Director of the Pulmonary Function Laboratory and the Pulmonary Rehabilitation Program, and former Chief of the Department of Medicine at Humana Hospital in Huntington Beach, California. Dr. Klein is also a Clinical Professor of Medicine in the Division of Pulmonary & Critical Care Medicine at the University of California, Irvine.

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³ This finding is made as a mitigating factor. It is not to be construed as a means of establishing negligence or other culpable conduct. (Evidence Code section 1151.)

22. Among other things, the expert witnesses testified regarding Complainant's allegations of various negligent acts set forth at Paragraph I, subparagraph (I) of the Accusation. Those allegations read as follows:

Respondent committed acts of negligence regarding the care and treatment of O.H. which included, but were not limited to, the following:

- (1) Respondent changed the patient's tracheostomy tube from a size 6 to a size 8 without a physician's order.
- (2) Respondent failed to follow the hospital's policy which stated a respiratory therapist could change a tracheostomy tube only upon a physician's order.
- (3) Respondent ignored the specific order of the pulmonologist to have the surgeon change the trach tube.
- (4) Respondent substituted his own clinical judgment for that of the physician, thereby failing to ensure the safety of the patient and placing her at risk.
- (5) Respondent failed to place the trach tube back in the trachea correctly, temporarily depriving the patient of oxygen which led to her becoming pulseless.
- (6) As a result of respondent changing the trach tube, the patient's trachea collapsed and she suffered subcutaneous emphysema when the volume of gas went under her skin instead of into her trachea. She then went into cardiac arrest, her condition became critical and she expired a few hours later.

23. Mr. Werner opined that Respondent's proceeding with the tracheostomy tube change without checking for a physician's order was both negligent and incompetent. He pointed out that, pursuant to Title 22 of the California Code of Regulations, a respiratory therapist is not permitted to perform such a procedure absent an order from a physician⁴. He also pointed out that, absent a physician's order, a respiratory care practitioner is not permitted to perform the procedure unless a life-threatening emergent situation exists and no physician can be reached. That scenario did not exist in this case.

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⁴ See, California Code of Regulations, title 22, section 51082.1, subdivision (a)(2). The language of that subdivision is almost identical to that in Business and Professions Code section 3702, subdivision (b). See also, California Code of Regulations, title 22, section 70617, subdivision (d).

24. Mr. Werner was correct. Business and Professions Code section 3702 states in relevant part:

Respiratory care as a practice means a health care profession employed under the supervision of a medical director in the therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities which affect the pulmonary system and associated aspects of cardiopulmonary and other systems functions, and includes all of the following:

[¶] . . . [¶]

(b) Direct and indirect respiratory care services, including but not limited to, the administration of pharmacological and diagnostic and therapeutic agents related to respiratory care procedures necessary to implement a treatment, disease prevention, pulmonary rehabilitative or diagnostic regimen prescribed by a physician and surgeon.

(c) Observation and monitoring of signs and symptoms, general behavior, general physical response to respiratory care treatment and diagnostic testing and (1) determination of whether such signs, symptoms, reactions, behavior or general response exhibit abnormal characteristics; (2) implementation based on observed abnormalities of appropriate reporting or referral or respiratory care protocols, or changes in treatment regimen, pursuant to a prescription by a physician and surgeon or the initiation of emergency procedures.

Business and Professions Code section 3705 states:

Nothing in this chapter shall be construed as authorizing a respiratory care practitioner to practice medicine, surgery, or any other form of healing, except as authorized by this chapter.

25. Mr. Werner further opined that Respondent was both negligent and incompetent by ignoring a physician's orders and attempting to perform the tube change himself, and by substituting his own clinical judgment for that of the physician. Respondent ignored the hospital's policy regarding tube changes by respiratory care practitioners even though he was the Director of the Respiratory Department and, by performing the procedure himself, Respondent violated the patient's right to participate.

26. On cross-examination, Mr. Werner was unable to verbally articulate the definitions of gross negligence, simple negligence or incompetence.⁵ However, he credibly testified that, when reviewing a file and preparing an expert witness report, he has the definitions with his written materials and bases his opinions on those definitions.

⁵ The distinctions between gross and simple negligence are irrelevant in this case since Respondent is charged with violations of Business and Professions Code section 3750, subdivision (f) which reads, "Negligence in his or her practice as a respiratory care practitioner."

27. Based on statements made in O.H.'s chart by various physicians, the timing of O.H.'s Code Blue in relation to the tube placement, the fact that O.H. immediately developed subcutaneous emphysema, and "the whole picture" (Mr. Werner's term), Mr. Werner believes Respondent did not properly intubate O.H. with the 8.0 tracheostomy tube. Although the presence of bilateral breath sounds generally implies proper tube placement, Mr. Werner believes that Respondent was either mistaken in his assertion that he heard bilateral breath sounds following the procedure, or that he heard bilateral breath sounds because the tube placement was partially, but not completely, correct.

28. Lastly, Mr. Werner opined that a respiratory care practitioner is required to document all pertinent events, as well as everything hospital policy requires. He stated that it is particularly important for a respiratory care practitioner to document events that happen in his/her presence. In this case, Respondent failed to document the Code Blue that occurred directly in front of him. Further, one cannot determine from Respondent's documentation whether Respondent witnessed the subcutaneous emphysema suffered by O.H.

29. Dr. Klein took a contrary view, opining that Respondent did not deviate from the standard of care and was not incompetent in any aspect of O.H.'s care.

30. Dr. Klein testified that, regardless of whether a physician's order existed or whether Respondent looked for one, Respondent was faced with an urgent (but not emergent) situation, which justified his undertaking the tube change. Because of the air leak in the 6.0 tube, the patient was not receiving the amount of air the ventilator was delivering. The patient was "in trouble" because she had no respiratory reserve. Dr. Klein asserted that something had to be done and "no one was around" to do it. Therefore, Respondent performed a life-saving procedure. Dr. Klein further testified that his opinion would not change even if Respondent had read and understood Dr. Yelamanchili's written order, because the patient was not stable and her condition could have deteriorated unless the air leak was a minor one. Dr. Klein believes the leak in the 6.0 tube was "moderate." Dr. Klein explained that a respiratory care practitioner should intervene, even without a physician's order, when a patient's ventilatory status is not stable and the situation is urgent. The situation need not be emergent for the intervention to be proper and within the standard of care. According to Dr. Klein, this situation was urgent and Respondent's actions were justified.

31. At the administrative hearing, Respondent was asked at least two or three times whether, at the time he changed O.H.'s tracheostomy tube, he considered the patient's condition an urgent situation. Respondent failed to answer that question. In response to the question, he stated only that an air leak existed with volume loss. A respiratory care practitioner requested his assistance and he helped her because he thought a physician had issued a verbal order. However, Respondent admitted that, had he been aware of Dr. Yelamanchili's written order and the absence of a verbal order, he never would have changed O.H.'s tracheostomy tube.

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32. Dr. Klein was incorrect in his testimony regarding the circumstances under which Respondent could change a patient's tracheostomy tube without a physician's order. Both statutory law and the standard of care require a physician's order unless an emergent situation exists. In this case, even if the situation was urgent, but not emergent, Respondent's actions were not justified. Dr. Klein was also incorrect in his assertion that no one was "around" to perform the tube change except for Respondent. The patient was in a hospital ICU. There was no evidence that Dr. Yelamanchili, Dr. Fischl or the Emergency Department physician were not "around." In fact, the Emergency Room physician immediately responded to the Code Blue which occurred as soon as Respondent changed the tube.

33. Respondent failed check for a verbal or written physician's order before changing the patient's tracheostomy tube. By so doing, he ignored an existing written physician's order. His failure to check the chart for an order constituted negligence, but not incompetence. (See Legal Conclusions 6, 7, and 8, *post*.) Complainant proved the allegations in Paragraph 11, subparagraphs (1), (2), (3) and (4) by clear and convincing evidence.

34. Dr. Klein also opined that Respondent properly placed the 8.0 tracheostomy tube, and that Respondent's actions were not the cause of O.H. developing subcutaneous emphysema and tension pneumothorax, or her decreased pulse and blood pressure, the events that led to the Code Blue being called. Rather, Dr. Klein testified that those events were caused by a ruptured bleb, a small air sac on the edge of the pleura. He believes that increased pressure from mechanical ventilation following the tube change caused the bleb to rupture. This would explain why Respondent and Ms. Salas heard bilateral breath sounds immediately before the ventilator's high pressure alarm sounded.

35. Mr. Werner's testimony on that issue is given more weight than that of Dr. Klein for the following reasons:

a. During his testimony, Respondent explained that the interior diameter of an 8.0 tracheostomy tube is greater than that of a 6.0. Therefore, since the settings on the ventilator did not change around the time of the tube exchange, the amount of air going through the tubes remained the same. However, because of its larger diameter, the amount of air pressure going through the 8.0 tube would be less, not greater, than the amount of air pressure that had gone through the 6.0 tube.

b. When he responded to the Code Blue, the Emergency Department physician noted that the 8.0 tube appeared to be out of the trachea.

c. The conclusion one must draw from Dr. Klein's reasoning is that the bleb rupture occurred independent of the tube change, and that Respondent's proper placement of the 8.0 tracheostomy tube had no effect on the bleb or the subsequent pneumothorax. In other words, once the bleb ruptured, the properly placed 8.0 tube could neither prevent nor stop air from entering the pleural space between the visceral and parietal pleura. However, the Code Blue was brought to a successful conclusion, and air no longer entered the pleural space once the Emergency Department physician removed the 8.0 tube and replaced it with a 6.0 tube. This leads to the conclusion that the tension pneumothorax was not caused by a ruptured bleb, but rather by improper placement of the 8.0 tracheostomy tube.

36. Respondent failed to properly place the 8.0 tracheostomy tube into O.H.'s trachea. His failure to do so constituted negligence, but not incompetence. (See Legal Conclusions 6, 7, and 8, *post*.) Complainant proved the allegations in Paragraph 11, subparagraphs (1) (5) and (6) by clear and convincing evidence.

37. Lastly, Dr. Klein opined that it was not necessary for Respondent to have made chart entries for the Code Blue and the subcutaneous emphysema because other members of the medical team had already done so, and because a scribe had recorded the entire Code Blue, a copy of which is in O.H.'s chart.

38. Mr. Werner's testimony on this issue is the more convincing for the following reasons:

a. By following Dr. Klein's reasoning, no one on the medical team would be responsible for charting any patient-related event, including an event at which that team member was personally present. No one would be required to chart because, presumably, everyone else would already have charted.

b. Dr. Klein's testimony regarding Respondent's charting obligations was inconsistent with his testimony earlier in the proceeding, when he testified that a respiratory care practitioner must record both what he/she does and "important events."

c. By its Policy No. TX-PC-66, DVH required its respiratory care practitioners to make chart entries which, in this case, would have included the subcutaneous emphysema and the Code Blue. Among other things, paragraph 6.18 of that policy requires a respiratory care practitioner to note skin condition and to "[d]ocument any complications, the nursing action taken and the patient's response to treatment."

39. For purposes of Business and Professions Code section 3750, subdivision (k), what Respondent charted was not "grossly incorrect." However, it was incomplete, and it was "grossly inconsistent" with the remainder of the chart notes written by the various medical team members. Business and Professions Code section 3750, subdivision (k) is written in the disjunctive.⁶ The allegations in paragraph 14 of the Accusation are written in the conjunctive. Accordingly, Complainant proved, by clear and convincing evidence, one, but not both, of the allegations in Paragraph 14 of the Accusation.

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⁶ Business and Professions Code section 3750, subdivision (k) reads in relevant part: The board may order the denial, suspension, or revocation of, or the imposition of probationary conditions upon, a license issued under this chapter, for any of the following causes:

[¶] . . . [¶]

(k) Falsifying, or making grossly incorrect, grossly inconsistent, or unintelligible entries in any patient, hospital, or other record.

Mitigating Factors

40. DVH conducted an investigation of the events of November 25, 2003. During that investigation, Respondent was completely honest and straightforward. He accepted responsibility for his part in the incident.

41. Following the incident, Respondent participated in the revision of the hospital policy regarding the circumstances under which a respiratory care practitioner may, and may not, change a tracheostomy tube. He then led an in-service within his department to familiarize the respiratory care staff with the revised policy.

42. Since that time, the administrators of DVH have continued to think so highly of Respondent's knowledge, skill and integrity that they appointed him Director of the Respiratory Unit of another medical center owned by the parent company.

43. At the administrative hearing, Respondent was again completely honest, even to the point of admitting that he would not have changed O.H.'s tracheostomy tube had he been aware of Dr. Yelamanchili's written order and the lack of a verbal order. Again, he accepted full responsibility and specifically chose not to blame his co-worker and subordinate for any aspect of the event.

Costs

44. Pursuant to Business and Professions Code section 3753.5, Complainant's counsel requested that Respondent be ordered to pay to the Board \$27,701.25 for its costs of investigation and prosecution of the case. The costs consist of \$3,648.75 for investigative services, \$918.75 for expert witness fees, and \$19,846.75 in Attorney General's fees.⁷

45. Although Respondent failed to sustain her burden of proof with respect to one of the four causes for discipline, the same investigation and trial preparation were required for the various causes for discipline. Accordingly, this is not a case in which a set-off for unproven matters is warranted. The requested costs, as limited in Footnote 7, are deemed just and reasonable.

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⁷ A discrepancy exists between the Declaration of Deputy Attorney General, Gloria L. Castro, and the Declaration of Costs signed by the Board's Executive Director, with respect to the Attorney General's fees for fiscal year 2005-2006. According to the former, 47.0 hours were spent at an hourly rate of \$146, for a total of \$6,862. According to the latter, 47.75 hours were spent, for a total of \$6,971.50. Complainant is awarded the lesser of those two sums.

LEGAL CONCLUSIONS

Pursuant to the foregoing Factual Findings, the Administrative Law Judge makes the following Legal Conclusions.

1. Cause exists to discipline Respondent's respiratory care practitioner's license for negligence in his practice as a respiratory care practitioner, pursuant to Business and Professions Code section 3750, subdivision (f), as set forth in Findings 6 through 19, 22 through 27, and 29 through 36.

2. Cause exists to discipline Respondent's respiratory care practitioner's license for making grossly inconsistent entries in a patient's record, pursuant to Business and Professions Code section 3750, subdivision (k), as set forth in Findings 28, 37, 38 and 39.

3. Cause does not exist to discipline Respondent's respiratory care practitioner's license for incompetence in his practice as a respiratory care practitioner, pursuant to Business and Professions Code section 3750, subdivision (o), as set forth in Findings 6 through 19, 22 through 27, and 29 through 36.

4. Cause exists to discipline Respondent's respiratory care practitioner's license for unprofessional conduct, pursuant to Business and Professions Code section 3755, as set forth in Findings 6 through 39, inclusive.

5. Cause exists to order Respondent to pay the costs claimed under Business and Professions Code sections 3753.1, 3753.5 and 3753.7, as set forth in Findings 44 and 45.

Negligence and Incompetence

6. Negligence and incompetence are not synonymous. Although they are not necessarily mutually exclusive, they are two distinct and disparate concepts.

The term "incompetency" generally indicates "an absence of qualification, ability or fitness to perform a prescribed duty or function." (*Pollack v. Kinder* (1978) 85 Cal.App.3d 833, 837.) Incompetency is distinguishable from negligence, in that one "may be competent or capable of performing a given duty but negligent in performing that duty." (*Id.*, at p. 838.) Thus, "a single act of negligence ... may be attributable to remissness in discharging known duties, rather than ... incompetency respecting the proper performance." (*Ibid.*, quoting from *Peters v. Southern Pacific Co.* (1911) 160 Cal. 48, 62 [116 P. 400].) The *Pollack* court concludes: "While it is conceivable that a single act of misconduct under certain circumstances may be sufficient to reveal a general lack of ability to perform the licensed duties, thereby supporting a finding of incompetency under the statute, we reject the notion that a single, honest failing in performing those duties--without more--constitutes the functional equivalent of incompetency justifying statutory sanctions." (85 Cal.App.3d at p. 839, italics in original.) (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1054-1055, 236 Cal.Rptr. 526.)

7. As the terms are defined in *Pollack and Kearnl, ante*, Complainant failed to sustain her burden of proving that Respondent was incompetent. The evidence did not establish that Respondent lacked the qualifications, ability or fitness to perform his functions and duties as a respiratory care practitioner or as Director of his department. It did not establish that Respondent was unaware that he was not to change a tracheostomy tube absent a physician's orders. It did not establish that Respondent was unaware that he was to check a patient's medical chart for physician's orders before performing a procedure such as a tracheostomy tube change. It did not establish that Respondent was ignorant of how to perform such a tube change, that he was inexperienced in doing so, or that he was unqualified to do so. On the contrary, the evidence established that Respondent is a qualified, competent and caring respiratory care practitioner.

8. However, the evidence also established that Respondent made two critical errors at approximately the same time, and on the same patient, first by failing to check the patient's chart for physician's orders, and then by improperly placing the 8.0 tracheostomy tube. Those errors constituted negligence—a remissness in discharging known duties, but they did not constitute incompetence.

Inconsistent Chart Entries

9. The evidence established that Respondent was responsible for charting the subcutaneous emphysema and the Code Blue, that he failed to do so, and that, as a result of his failure to make those chart entries, his charting was grossly inconsistent with that of the other medical team members. As explained above, the fact that others may have charted the same events does not exculpate Respondent from the responsibility of doing so himself, since relieving him of the responsibility of charting events that are documented elsewhere in the chart would also relieve the other team members as well, a concept antithetical to proper medical record keeping and appropriate medical care and practice.

Unprofessional Conduct

10. Business and Professions Code section 3755 states:

The board may take action against any respiratory care practitioner who is charged with unprofessional conduct in administering, or attempting to administer, direct or indirect respiratory care. Unprofessional conduct includes, but is not limited to, repeated acts of clearly administering directly or indirectly inappropriate or unsafe respiratory care procedures, protocols, therapeutic regimens, or diagnostic testing or monitoring techniques, and violation of any provision of Section 3750. The board may determine unprofessional conduct involving any and all aspects of respiratory care performed by anyone licensed as a respiratory care practitioner. Any person who engages in repeated acts of unprofessional conduct shall be guilty of a misdemeanor and shall be punished by a fine of not more than one thousand dollars (\$1,000), or by imprisonment for a term not to exceed six months, or by both that fine and imprisonment.

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11. Respondent's errors and omissions did not satisfy the criteria listed in Business and Professions Code section 3755. Those criteria call for "repeated acts." Respondent did not perform "repeated acts." He made two separate errors in connection with a single patient—he failed to check the chart for a physician's order before performing a procedure requiring such an order, and he improperly placed a tracheostomy tube. In connection with a related but disparate issue, he made chart entries that were grossly inconsistent with those of the other medical team members.

12. Although the criteria listed in Business and Professions Code section 3755 are not exhaustive, the only acts alleged in the Accusation as constituting unprofessional conduct pursuant to that statute are those contained in Paragraph 11, subparagraph (I), the same allegations made with respect to negligence, incompetence and grossly incorrect and grossly inconsistent chart entries. As such, the allegations made in connection with Business and Professions Code section 3755 are duplicative and redundant. Although, technically, cause exists to discipline Respondent's license pursuant to Business and Professions Code section 3755, no purpose is served by finding unprofessional conduct pursuant to that statute when the very same allegations were proven to establish negligence and the making of grossly inconsistent chart entries.

The Discipline

13. The parties strongly disagreed over whether, if cause for discipline was found to exist and Respondent was placed on probation, his practice should be restricted such that he was prohibited from serving as a director of a hospital respiratory care department. As stated above, Respondent's professional reputation, both as a respiratory care practitioner and as a department director, is excellent, and his license has never before been subject to discipline. The only blemish on his record occurs today, when he has been found to have made two almost simultaneous practice errors and two simultaneous (or nearly so) charting errors. He was not found to be incompetent. Respondent immediately accepted responsibility for his actions and, by helping to re-write the hospital's policy, took steps to ensure that such actions would not re-occur. Discipline must be imposed in this case, but requiring Respondent to be removed from his present positions would be overly harsh, punitive and unnecessary.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Respiratory Care Practitioner License No. 18493, issued to Joseph Ernest Carrillo, is revoked. The revocation is stayed, and Respondent is placed on probation for a period of five years subject to the following terms and conditions:

1. Respondent shall obey all laws, whether federal, state, or local. Respondent shall also obey all regulations governing the practice of respiratory care in California.

Respondent shall notify the Board in writing within 14 days of any incident resulting in his arrest, or charges filed against, or a citation issued against Respondent.

2. Respondent shall file quarterly reports of compliance under penalty of perjury, on forms to be provided, to the probation monitor assigned by the Board. Omission or falsification in any manner of any information on these reports shall constitute a violation of probation and may result in the filing of an accusation and/or a petition to revoke probation against Respondent's respiratory care practitioner license.

Quarterly report forms will be provided by the Board. Respondent is responsible for contacting the Board to obtain additional forms if needed. Quarterly reports are due for each year of probation and the entire length of probation as follows:

For the period covering January 1st through March 31st, reports are to be completed and submitted between April 1st and April 7th.

For the period covering April 1st through June 30th, reports are to be completed and submitted between July 1st and July 7th.

For the period covering July 1st through September 30th, reports are to be completed and submitted between October 1st and October 7th.

For the period covering October 1st through December 31st, reports are to be completed and submitted between January 1st and January 7th.

Failure to submit complete and timely reports shall constitute a violation of probation.

3. Respondent shall comply with requirements of the Board appointed probation monitoring program, and shall, upon reasonable request, report to or appear at a local venue as directed.

Respondent shall claim all certified mail issued by the Board, respond to all notices of reasonable requests timely, and submit Annual Reports, Identification Update reports or other reports similar in nature, as requested and directed by the Board or its representative.

Respondent is encouraged to contact the Board's Probation Program at any time he has a question or concern regarding the terms and conditions of his probation.

Failure to appear for any scheduled meeting or examination, or to cooperate with the requirements of the program, including timely submission of requested information, shall constitute a violation of probation and may result in the filing of an accusation and/or a petition to revoke probation against Respondent's respiratory care practitioner license.

4. All costs incurred for probation monitoring during the entire period of probation shall be paid by Respondent. The monthly cost may be adjusted as expenses are reduced or increased. Respondent's failure to comply with all terms and conditions may also cause this amount to be increased.

All payments for costs are to be sent directly to the Respiratory Care Board and must be received by the date(s) specified. Periods of tolling will not toll the probation monitoring costs incurred.

If Respondent is unable to submit costs for any month, he shall be required instead to submit an explanation of why he is unable to submit the costs, and the date(s) he anticipates being able to submit the costs including payment amount(s). Supporting documentation and evidence of why Respondent is unable to make such payment(s) must accompany this submission.

Respondent is hereby notified that failure to submit costs timely is a violation of probation and submission of evidence demonstrating financial hardship does not preclude the Board from pursuing further disciplinary action. However, if Respondent provides evidence and supporting documentation of financial hardship, such information may delay further disciplinary action.

In addition to any other disciplinary action taken by the Board, an unrestricted license will not be issued at the end of the probationary period and the respiratory care practitioner license will not be renewed, until such time all probation monitoring costs have been paid.

The filing of bankruptcy by Respondent shall not relieve Respondent of his responsibility to reimburse the Board for costs incurred.

5. Respondent shall be employed a minimum of 24 hours per week as a respiratory care practitioner for a minimum of two-thirds of his probationary period.

Respondent may substitute successful completion of a minimum of 30 additional continuing education hours, beyond that which is required for license renewal, for each eight months of employment required. Respondent shall submit proof to the Board of successful completion of all continuing education requirements. Respondent is responsible for paying all costs associated with fulfilling this term and condition of probation.

6. Respondent shall be required to inform his employer, and each subsequent employer during the probation period, of the discipline imposed by this decision by providing his supervisor and director and all subsequent supervisors and directors with a copy of the decision and order, and the Accusations in this matter, prior to the beginning of or returning to employment or within 14 days from each change in a supervisor or director.

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If Respondent is employed by or through a registry, Respondent shall make each hospital or establishment to which he is sent aware of the discipline imposed by this decision by providing his direct supervisor and administrator at each hospital or establishment with a copy of this decision, and the Accusation in this matter prior to the beginning of employment. This must be done each time there is a change in supervisors or administrators.

The employer will then inform the Board, in writing, that he/she is aware of the discipline, on forms to be provided to Respondent by the Board. Respondent is responsible for contacting the Board to obtain additional forms if needed. All reports completed by the employer must be submitted from the employer directly to the Board.

Respondent shall execute a release authorizing the Board or any of its representatives to review and obtain copies of all employment records and to discuss and inquire about Respondent's probationary status with any of Respondent's supervisors or directors.

7. Respondent shall notify the Board, and appointed probation monitor, in writing, of any and all changes of employment, location, and/or address within 14 days of such change. This includes but is not limited to applying for employment, termination or resignation from employment, change in employment status, and change in supervisors, administrators or directors.

Respondent shall also notify his probation monitor AND the Board IN WRITING of any changes of residence or mailing address within 14 days. P.O. Boxes are accepted for mailing purposes, however Respondent must also provide his physical residence address as well.

8. Respondent shall pay to the Board a sum not to exceed the costs of the investigation and prosecution of this case. That sum shall be \$27,701.25 and shall be paid in full directly to the Board, in equal quarterly payments, within 12 months from the effective date of this decision. Cost recovery will not be tolled.

If Respondent is unable to submit costs timely, he shall be required instead to submit an explanation of why he is unable to submit these costs in part or in entirety, and the date(s) he anticipates being able to submit the costs including payment amount(s). Supporting documentation and evidence of why Respondent is unable to make such payment(s) must accompany this submission.

Respondent is hereby notified that failure to submit costs timely is a violation of probation and submission of evidence demonstrating financial hardship does not preclude the Board from pursuing further disciplinary action. However, if Respondent provides evidence and supporting documentation of financial hardship, such information may delay further disciplinary action.

Consideration to financial hardship will not be given should Respondent violate this term and condition, unless an unexpected AND unavoidable hardship is established from the date of this order to the date payment(s) is due.

The filing of bankruptcy by Respondent shall not relieve Respondent of his responsibility to reimburse the Board for these costs.

9. Periods of residency or practice outside California, whether the periods of residency or practice are temporary or permanent, will toll the probation period but will not toll the cost recovery requirement, nor the probation monitoring costs incurred. Travel out of California for more than 30 days must be reported to the Board in writing prior to departure. Respondent shall notify the Board, in writing, within 14 days, upon his return to California and prior to the commencement of any employment where representation as a respiratory care practitioner is/was provided.

10. Respondent shall maintain a current, active and valid respiratory care practitioner license for the length of the probation period. Failure to pay all fees and meet continuing education requirements prior to his license expiration date shall constitute a violation of probation.

15. Respondent shall be required to complete additional Continuing Education beyond that which is required for license renewal. A minimum of 15 additional hours is required for each year of probation. Respondent shall submit proof to the Board of successful completion of all continuing education requirements.

16. Within six months of the effective date of this decision, Respondent shall be required to take and pass an examination on the Respiratory Care Practice Act, the Respiratory Care Practitioner Regulations, and other provisions that affect the practice of respiratory care. This examination shall be taken on a date specified by the Board.

Respondent shall be responsible for paying all costs for any scheduled examination(s) prior to taking any examination [\$50 per each scheduled exam].

Failure to appear for any scheduled examination, or to pass the examination after two attempts shall constitute a violation of probation and shall result in the filing of an accusation and/or a petition to revoke probation against Respondent's respiratory care practitioner license.

Failure to submit timely fees for one or more examinations shall constitute a violation of probation.

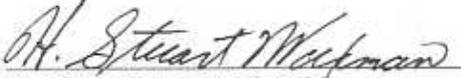
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17. If Respondent violates any term of the probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If a petition to revoke probation is filed against Respondent during probation, the Board shall have continuing jurisdiction and the period of probation shall be extended until the matter is final. No petition for modification of penalty shall be considered while there is an accusation or petition to revoke probation or other penalty pending against Respondent.

18. Upon successful completion of probation, Respondent's license shall be fully restored.

DATED: June 12, 2006


H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings

BEFORE THE
RESPIRATORY CARE BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

JOSEPH ERNEST CARRILLO
795 Marlboro Court
Claremont California

Respiratory Care Practitioner
License No. 18493,

Respondent.

Case No. R-1969

OAH No. L2005080393

**ORDER CORRECTING MISTAKE IN
PROPOSED DECISION**

On June 12, 2006, Administrative Law Judge H. Stuart Waxman (ALJ) of the Office of Administrative Hearings issued a proposed decision in the above-captioned case. Thereafter, on June 19, 2006, Jennifer Porcalla, Enforcement Analyst (agency), faxed a letter to Presiding Administrative Law Judge, Janis S. Rovner of the Office of Administrative Hearings, asking this office to correct an error found in ALJ Waxman's proposed decision.

The suggested correction to the proposed decision is as follows: In the Factual Findings at page 11, paragraph 45, line 1, the word "Respondent" should be changed to "counsel". Actually, the proposed decision should be corrected to change the word "Respondent" to "Complainant". The proposed correction is minor and technical in nature. ALJ Waxman has confirmed to the undersigned that this was a technical error on his part.

GOOD CAUSE appearing, the following Order is issued:

1. The correction is authorized by law.
2. The proposed decision is hereby corrected as follows: In the Factual Findings at page 11, paragraph 45, line 1, the word "Respondent" is changed to "Complainant".
3. This order and the agency's letter (attached to this Order) are made a part of the record in this case.

IT IS SO ORDERED.

Dated: June 27, 2006


Janis S. Rovner
Administrative Law Judge
Office of Administrative Hearings