

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

In the Matter of the Accusation Against:

ALBERT DALE BEITH,
Herald, California 95638

Respiratory Care Practitioner
License No. 775

Respondent.

Case No. 1H 2008 392

OAH No. 2009060989

PROPOSED DECISION

Administrative Law Judge Stephen J. Smith, Office of Administrative Hearings, State of California heard this matter in Sacramento, California on November 24 and 25, and December 17, 2009.

David Carr, Deputy Attorney General, and Catherine Santillan, Senior Legal Assistant, Office of the Attorney General, Department of Justice, represented the Respiratory Care Board (the Board).

Albert Dale Beith was present and was represented by Michael Meehan, Attorney at Law.

Evidence was received and the record was left open for the parties to submit written closing arguments. The Board's Closing Argument was received January 19, 2010. Respondent's Closing Argument was received February 4, 2009. The Board's Reply Argument was received February 9, 2010. The Closing Arguments and Reply were marked as Exhibits and were received into the record as argument.

The record was closed and the matter was submitted on February 10, 2010.

FACTUAL FINDINGS

1. Colleen Whiteside made the charges and allegations contained in the Accusation in her official capacity on behalf of Stephanie Nunez, who is the Executive Officer, Respiratory Care Board (Board), Department of Consumer Affairs, State of

California. The Accusation was filed with the Board on April 16, 2009, and was timely served on respondent. The Board has jurisdiction to revoke, suspend or otherwise impose disciplinary action upon any respiratory care practitioner in the State of California, provided cause for such action is proved by clear and convincing evidence.¹ In addition, the Board has jurisdiction to impose, modify or revoke terms and conditions of probation on any respiratory care practitioner licensee.²

2. Respondent, through counsel, timely filed a Notice of Defense to the Accusation. The matter was set for an evidentiary hearing before an Administrative Law Judge of the Office of Administrative Hearings.

License History

3. The Board issued respondent Respiratory Care Practitioner (RCP) license number 755 on April 19, 1985. Respondent was one of the original licensees of the Board, having been a practicing RCP before the enactment of legislation requiring licensing and regulation of RCPs in the State of California. He was "grandfathered" as an original licensee when the licensing requirements took effect. There is no record of previous disciplinary action against respondent by the Board.

Employment History

4. At all times relevant to this Decision, respondent was employed as a RCP with Sutter Amador Hospital, Jackson, California (Sutter Amador). Sutter Amador is a small acute care hospital serving a predominately rural community in the Mother Lode area of California. Respondent had been employed as a RCP at Sutter Amador for 14 years in 2008.

Respiratory Care Practice Commonly Includes Performing EKGs

5. RCPs on staff at Sutter Amador perform professional duties ordinarily expected of RCPs, such as ventilator placement and monitoring, breathing therapies and treatments, pulmonary support, lung function testing and so forth, duties within the scope of RCP professional license status. In addition, from time to time, Sutter Amador RCPs are assigned to assist in other Departments with medical testing and support tasks. In particular, Sutter Amador RCPs are routinely assigned to perform electrocardiograms (EKG) when the usual work for RCPs was caught up and there was need for assistance in performing EKGs. As the head of the RCP Department at Sutter Amador testified, it was not uncommon for a staff RCP working at Sutter Amador to perform EKGs from time to time, as the hospital had need of assistance. The Board's expert testified that having hospital staff RCPs perform

¹ Business and Professions Code sections 3750, 3750.5, *Ettinger v. Medical Board of California* (1982) 135 Cal.App. 3d 835, 856.

² Business and Professions Code section 3750.

EKGs at other California hospitals is common, and that she has performed thousands of EKGs in her employment at four different Southern California hospitals.

First EKG-April 10, 2008

5. Respondent was on duty at Sutter Amador working in his professional capacity as a RCP on April 10, 2008. Respondent was summoned to the medical testing area to perform some EKGs, as the Medical Testing Department was very busy and the RCP needs of the hospital were met.

6. Respondent was assigned to perform an EKG on patient K.S. Respondent met K.S. in the assigned waiting area and escorted her to the examination room. Respondent and K.S. had never met before. Respondent provided K.S. a hospital gown and instructed her to disrobe from the waist up and put on the gown. He left the room while she changed.

7. Respondent returned to the room. He explained the procedure and he prepared and placed the ECG leads on K.S. and readied the machine for the test. During this set-up process, respondent asked K.S. why she was having the EKG. K.S. told respondent that she was having surgery. She told him that her breast implants had failed because they hardened, and she was going to have the implants replaced. Respondent asked K.S. if he could "touch." K.S. understood this to mean respondent was asking permission to touch her breasts. Before K.S. could refuse or say anything, respondent touched her right breast just below her nipple with his fingertips for a "couple of seconds," over her hospital gown. Respondent did not have a EKG lead in his hand and the touching was not inadvertent.

8. K.S. was shocked speechless. K.S. was holding her gown up slightly at the time to allow respondent to place a lead without exposing her breasts. Respondent then asked, "Can I look?" Again, before she could respond, respondent lifted K.S.'s gown further, exposing her breasts and looked at her breasts for a brief time. Respondent commented on "how good they look," referring to K.S.'s breasts.

9. Respondent let K.S.'s gown fall back into place and pressed the button on the EKG machine to run the test. The EKG machine printed a report. Respondent's supervisor testified that respondent used a EKG machine that detects and alerts the operator if the EKG leads are crossed or placed inappropriately, and, if the leads are crossed or placed incorrectly, the machine prints a report showing the test result is invalid. It was not disputed that the EKG machine has a feature that alerts the operator if the EKG leads are misplaced or crossed. The purpose of this feature is to avoid inconvenience that results from having a patient have to return for a retest for a simple and easily corrected error that can be rectified on site in a matter of minutes. The EKG operator, upon reading the note on the test that the reading is invalid due to misplacement of the leads, can correct the problem and rerun the test right away. There was no evidence the EKG test result print out respondent produced on April 10 when he performed the EKG on K.S. was invalid or bore any indication the leads had been crossed or misplaced. Respondent looked at the report of the test results and

communicated to K.S. that the test print result was valid by commenting, "Everything looks good."

10. Respondent slowly removed the EKG leads, so slowly that K.S. found the process quite awkward and "creepy." Respondent started to leave the room so K.S. could dress. As K.S. was preparing to dress, respondent commented that K.S. "would have to return" and "show them" to him after the surgery was completed. K.S. understood the comment to mean that he was inviting her to return to the hospital after her surgery to show him her breasts. Respondent took the EKG report and put it into a box in the lab area where all EKG reports made that day were collected.

11. K.S. was completely caught off guard and taken aback by respondent's conduct. She located a friend who worked at the hospital and told her what had just happened to her while respondent was performing the EKG. K.S. left the hospital and returned to work. Upon her arrival at work, she immediately reported to a friend that when she was having her EKG, the man performing the test "groped me on my breast." The work friend to whom she first reported being groped did not testify and was not identified.

Second EKG-April 11, 2008

12. K.S. was required to return to Sutter Amador Hospital the next day for blood work and other tests. She encountered a friend who worked in the testing area and got into a conversation, when respondent appeared. He greeted K.S. and told her that he was just getting ready to call her, because "the cardiologist told me that I hooked up the wires wrong" and you will have to have your EKG from the day done over because the EKG was invalid. K.S. was anxious to get her EKG and other tests done because her surgery was scheduled for April 17, and her surgery could not occur until the tests were completed and assessed by her physician. Respondent told K.S. he could perform a retest right away. K.S. did not want to allow respondent to perform the retest, but felt she did not have a choice due to the urgent need to get her tests completed. K.S. reluctantly agreed and respondent took her to a testing room. Respondent performed the second EKG without incident.

Missing EKGs And Report Of Misconduct April 16, 2008

13. K.S. got a call from her physician on April 16, 2008, advising her that he still had not received her EKG. K.S. returned to Sutter Amador the same day, went to the Medical Records Desk and asked for a copy of her EKG. She understood at the time she made this request that the first EKG performed April 10 was invalid, based upon respondent's statements on April 11, so she requested a copy of the April 11, 2008 EKG. The medical records clerk found the April 10, 2008, EKG without difficulty, but no one in the Medical Records Department could find any record of the second EKG result, or any evidence that the second EKG ever occurred. K.S. took the April 10 EKG to her physician who told her the test was valid and acceptable.

14. K.S. was very upset and immediately reported respondent's conduct to Ms. Turner, an employee of Sutter Amador Hospital Administration. K.S. told Ms. Turner that she was concerned that her correct EKG was not sent to her surgeon and that it could not be found in the hospital's medical records. She then told Ms. Turner that during the April 10 EKG, respondent felt her breasts after asking if he "could feel," but before she could decline. She said respondent was a "nice guy" but that she thought it was inappropriate that he would feel her breasts during the test procedure. She also reported the retest the following day, and her confusion regarding which test was accurate, as she needed to have an accurate test to provide her surgeon right away. Ms. Turner directed a medical records search. No trace of the April 11 EKG could be found. The April 10 EKG was located. Ms. Turner arranged to have a staff physician read the EKG. Upon confirmation from the physician that the EKG was normal and a valid test, Ms. Turner arranged to have the April 10 EKG delivered to K.S.'s surgeon.

15. Respondent destroyed the print out of the second EKG before he left work on April 11, 2008.

First Investigative Interview-April 17, 2008

16. Respondent was summoned to an investigative interview with his supervisor Mr. Sammons, Head of the Hospital's Cardio/Pulmonary Units and Sleep Laboratory, and Ms. Santos, the Hospital's Human Resources (HR) Director on April 17, 2008. Respondent was informed of the nature and details of K.S.'s complaint. The interviewers solicited respondent's reply to K.S.'s allegations, advising respondent that they wanted to hear his side of things, and he was provided an opportunity to respond. Both hospital officials took contemporaneous notes of what respondent said to them on April 17 in reply to K.S.'s claims regarding his conduct.

17. When providing his response to K. S.'s claims, respondent told the hospital and HR officials that he agreed with K.S.'s report of the setting and how he and K.S. came into contact with one another, and that the two of them conversed casually about her upcoming surgery as he was preparing to perform the EKG. Respondent then told the hospital interviewers that he asked K.S. what she was going to do. He told them she said, "Have these done" as she pulled down her gown, showed him her bare breasts and invited him to touch her breasts by saying, "Here, touch." He accepted her offer and did touch her breasts and commented how firm they were, briefly, "out of curiosity," as he said his wife was contemplating having a similar surgery. He told his interviewers that after he touched her breasts he thought maybe he should have not done that. Describing his conduct, respondent told his interviewers, "That was stupid, please tell the patient I'm sorry." He advised that he did not recall asking to feel her breasts. At the end of the testing, respondent said K.S. asked him if he "was coming back" after her surgery so she could show her breasts to him post-surgery. He said no.

18. The interviewers then asked respondent if he performed a second EKG. Respondent replied he did. Respondent told the interviewers that he thought he had put the leads on wrong for the first EKG. The interviewers asked respondent how he knew the leads were on wrong for this particular test. Respondent did not directly reply to this question, but said that he thought the report showed the leads were on wrong but perhaps he was looking at another report. Respondent acknowledged he saw K.S. the next morning at the hospital in reception. He said to K.S. that he thought he did her test wrong and asked her if he could redo it. She agreed to the retest. Respondent told the interviewers that he did not log the April 11 retest EKG or turn it in to medical records because he found the April 10 EKG, looked at it and saw it was valid after all. He told the interviewers he destroyed the second EKG print out. Respondent did not say anything at this time about not recalling the patient's name.

K.S. Interview

19. K.S. was later interviewed by the same interviewers as part of their investigation. She was interviewed on April 24, 2008. K.S.'s statement to the head of HR and respondent's supervisor was consistent in all material details with her testimony about her encounters with respondent set forth just above in Factual Findings 5-14, inclusive.

Second Investigative Interview-April 29, 2008

20. Respondent was summoned to a second, follow-up interview with the head of HR and his supervisor on April 29, 2008. Respondent "changed his story" markedly in this second interview, according to the testimony of respondent's supervisor. Respondent denied touching K.S. other than incidental touching when placing the leads on her for the EKG.

21. Mr. Sammons and Ms. Santos reminded respondent of his statements made during the first interview, where he told them that he touched her breasts after she asked him if he wanted to touch her breasts. The HR Director read his previous statement back to him from her notes made at the time of the first interview. Respondent denied she asked him the question and he also denied he asked K.S. anything of the sort. Respondent claimed he was confused during the first interview about the questions they asked and stated he should have asked for clarification. Mr. Sammons said respondent did not indicate any lack of clarity in the first interview and pointed out that respondent did not ask for clarification of anything said in the interview. The HR Director then told respondent that the patient "stuck to her statement," that the patient was uncomfortable with his conduct, so his employment was being terminated. Sutter Amador reported the termination to the Board, triggering this action.

Respondent's Statement To Board

22. The Board solicited a statement from respondent as part of its action against respondent's license. Respondent submitted a brief one page statement to the Board on July 24, 2008. Respondent wrote that there was no inappropriate touching of the patient in either

EKG. He wrote that he has "done thousands of EKGs and hundreds of stress EKGs" without any complaint. He stated that during logging of EKGs, "one did not look right." He noticed that it was his and that he had performed the EKG that morning. He sent the EKGs along to Medical Records.

23. Respondent then wrote that he did see the patient the next morning when she called his name and responded to her when she asked if she remembered him. He wrote that K.S. asked him "how her EKG was" and he responded that he may have made a mistake. She asked if it would delay her surgery. He told her he did not know but that her surgeon would know, and that she could choose to redo the test or let the surgeon decide. She chose to have the EKG repeated and asked him to perform the test. After the second EKG, much later in the afternoon, after he had been occupied with other duties, he returned to the department where he was working earlier and found he had left the second EKG on the counter. The second EKG did not have a face sheet. He got angry with himself because he did not know the patient's name and left the face sheet off the test. Uncertain what to do with the second test, he put it in the "shred bin."

24. Respondent finished his written statement to the Board by asking why the patient would allow him to perform a second EKG on her if he inappropriately touched her on the first test. He stated that he would not permit such a thing, if it were him.

25. Other than the fact that a good deal of what respondent wrote is false, respondent's written statement to the Board is more noteworthy more for what it omitted than for what he wrote. Respondent's statement is silent regarding claim he made in his testimony that K.S. invited respondent to look at her breasts and dropped her gown to show him her breasts. There was also no mention of respondent's additional claim in his testimony that K.S. invited respondent to touch her breasts and to look at her breasts again after her surgery.

Evidentiary Hearing Testimony

26. Respondent's testimony at the evidentiary hearing was the final installment in a nearly year long exercise in serial untruthfulness. Respondent testified he "never" exposes the breasts of any female patient, because that would be "inappropriate." He agreed he and K.S. were chatting about her upcoming surgery, and when she told him she was having breast surgery, he replied that was "too bad," assuming she was having breast cancer surgery. She corrected him and said she was going to have a muscle moved from over her breast, which he assumed was some sort of breast augmentation procedure. He testified that he "was not paying much attention" to the conversation as he was placing the leads. He then said his wife was thinking of having a similar surgery and that K.S. said she should "go for it." He then testified that K.S. "lifted her gown up over her breast and showed me the scar over her nipple." He said he knew it was inappropriate for him to look, that he "turned away so as to not look."

27. Respondent testified that when the EKG was completed, he escorted K.S. out of the test room. As they walked out, he testified K.S. said that she would "show them" to him when the surgery was done. He said "no thanks." Later he saw the EKG paperwork in the box where such tests were collected. He testified the EKG "did not look like the right one" to him. He testified that the QRS lines "looked wrong." He testified he took the EKG to Medical Records and dropped it off. He expected "this one to come back."

28. Respondent agreed in his testimony that he did perform a second EKG on K.S. the following day. He testified that he was in the reception area the following morning when K.S. leaned around the partition and greeted him, asking if he remembered her. He replied "yeah I vaguely recall you." He told her of the need for a redo of the test and apologized for making an error. He performed the test and K.S. left. Later he found the EKG test report he had performed earlier that day "in his things," but discovered the report did not have a patient tag. He testified he did not log in this patient when he performed this EKG, and that he tried, but could not remember the patient's name.

29. Respondent portrayed himself in his testimony as a victim, both of K.S.'s claims, of the hospital's inquiry process and for his interviewers misconstruing his comments during the first interview. He told Mr. Sammons and Ms. Santos that he did not need a representative at the first interview because he "did nothing wrong to warrant one." He testified that the last thing he heard during the first interview was when he was told the patient accused him of lifting her gown and exposed her breasts, after that point he was in shock and stared at the wall. He claimed to have not heard or consciously responded to the remainder of the interview. When asked if he admitted touching her breasts, he replied, "Heavens no." He testified he was "confused about what they were trying to make me say," denying that he had admitted the touching to Mr. Sammons and Ms. Santos in the first interview, as they testified. He repeated his denial that he touched K.S.'s breasts or that he exposed her breasts. He repeated his statement that "she showed them to me." He testified he "turned away" to get his papers, because he "did not want to look," and "I don't need to look."

Credibility Assessments

30. K.S.'s testimony was credible and persuasive. Respondent's was not. K.S.'s several statements detailing the incidents on April 10 and 11, 2008 were consistent in all material respects. Respondent's were not. Respondent's testimony was profoundly lacking in credibility. K.S. testified truthfully about the incidents. Respondent did not.

31. Respondent's testimony was colored by significant undertones of a contrived indignity. Respondent's resentment was poorly disguised as he painted K.S. as the person initiating and engaging in the sexually inappropriate conduct and the aggressor in creating the situation that resulted in his losing his job at Sutter Amador.

32. Perhaps most striking about respondent's testimony was respondent's repeated insistence that Mr. Sammons and Ms. Santos both lied about what he said during the first interview on April 17. He went as far as accusing Ms. Santos of "making up" what she said in her testimony about his reply to the allegations. Respondent failed to identify any reason they would both lie about what he said in the first interview, or why their contemporaneous notes of the interview were entirely consistent to their testimony and contradicted his own. Respondent did not appeal his termination, and there is no criminal or civil action pending that the hospital personnel might be motivated to protect. Respondent's testimony that he did not lie because he "does not do things like that" was painfully self-contradicted.

33. Respondent got seriously trapped in the logical inconsistencies of the various iterations of his statements. His several explanations of why he performed the second EKG and why he destroyed the second EKG report were individually unpersuasive and collectively ludicrous. The lack of credibility of these explanations regarding the second EKG tainted his other statements, but the taint was not necessary to determining the credibility of respondent's several alternatives of what happened during the first EKG. Those statements failed of credibility entirely on their own. Respondent found himself trapped in a web of deceit of his own making, spun in several separate efforts. Respondent got trapped when he was forced to acknowledge in his testimony that he could not remember the name of the breast implant patient who exposed her breasts and showed him her nipple scar, and offered to return after her surgery to show him her breasts again, and that this failure of memory was just a day after this shocking incident when he was trying to place her name with the second EKG report that he claimed did not have a name. This statement was patently false on its own, but this was even more obvious when other testimony revealed the patient's name was written in a hospital log of all tests performed on April 10. The patient name information was easily available, had respondent been truly interested in obtaining it. Respondent found himself trapped again when he was backed into acknowledging that he still claimed to not know the name of the patient for whom he had produced two back to back EKGs he claimed were both invalid, produced within 24 hours time, after testifying that he had performed thousands of previous EKGs without problems or complaints. Respondent got trapped yet again when he acknowledged that hospital protocols and procedures requires notification of his supervisor if a professional performing an EKG produces an invalid test that requires the patient to return for a retest. Respondent acknowledged that he did not inform his supervisor or anyone in authority at the hospital that he had performed an invalid EKG on April 10 for a presurgical patient whose surgery was pending just a few days hence. Respondent also indirectly admitted he violated hospital policy by destroying the second EKG report on his own.

Costs

34. Evidence of the costs of investigation and enforcement of the action spent by the Board was introduced in the form of a declaration of the Board's Executive Officer, dated December 15, 2009, submitted pursuant to Business and Professions Code sections 3753.5 and 3753.7. The costs consist of a claim for the services of the Deputy Attorney General and "Paralegal" totaling of \$17,858.25. The declaration of the Executive Officer contains no

detail other than the number of hours billed by the Deputy Attorney General in two different fiscal years, and the rates for each. The declaration seeks recovery for 9.25 hours of Deputy Attorney General time (\$1,572.50) and a total of 136.75 hours of paralegal time at a cost of \$15,873.25. Expert witness fees of \$412.50 were also enumerated and sought. There is no detailed billing memorandum attached to the declaration, itemizing the tasks performed and the hours spent for each of the tasks. There is no information provided in the declaration other than the classifications of the personnel performing the work, the hours spent and the rate for billing.

35. The costs are presumed reasonable pursuant to the language of the statute, however, the Administrative Law Judge is required to make an independent analysis of the costs claim.³ The case was not particularly complex, and came to the Board all but fully investigated and prepared, following a full investigation by the Sutter Amador Hospital. The Sutter Amador Hospital investigation came complete to the Board with all percipient witness statements already obtained and documented. Additionally, there had already been a separate and independent criminal investigation, complete with additional statements obtained from all the percipient witnesses and respondent, by the Amador County Sheriff's Department. Most of the preparatory efforts were evidently invested in needless and duplicative tasks. Time was also spent obtaining and attempting to present expert testimony that was not necessary to the case, and in efforts to present the case entirely via hearsay declarations. The costs claim reflects a claim of almost a month's (17 plus days) of full time work by the "paralegal." The costs declaration has no evidence of how this rather large amount of time was spent, with no evidence of extensive research, document assembly or interviews of witnesses. Until the Deputy Attorney General stepped in to assist, the case was prepared and presented clumsily and poorly, and respondent should not be held liable for the choices the Board and the Attorney General's office made regarding how to prepare and present this case.

36. The costs claim is unreasonable and excessive on its face. A reasonable amount for costs of investigation and enforcement, considering the nature and complexity of the case, is \$5000.00.

LEGAL CONCLUSIONS

1. "The burden of proof in administrative proceedings involving the revocation or suspension of a professional license is clear and convincing proof to a reasonable certainty."⁴ "Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to

³ *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32.

⁴ *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App. 3d 835, 842, *James v. Board of Dental Examiners* (1985) 172 Cal. App. 3d 1096, 1105

command the unhesitating assent of every reasonable mind.”⁵ The burden of clear and convincing evidence was applied to each allegation of the Accusation.

First Cause For Discipline

2. Business and Professions Code section 3750 provides, in pertinent parts, that 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:

¶...¶

(f) Negligence in his or her practice as a respiratory care practitioner.

¶...¶

(h) The aiding or abetting of any person to violate this chapter or any regulations duly adopted under this chapter.

¶...¶

(j) The commission of any fraudulent, dishonest or corrupt act which is substantially related to the qualifications, functions and duties of a respiratory care practitioner.

¶...¶

(o) Incompetence in his or her practice as a respiratory care practitioner.

¶...¶

3. Business and Professions Code section 726 provides as follows: 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.

4. Respondent violated section 3570, subdivision (j) and section 726. Respondent engaged in acts of sexual misconduct with a patient on April 10, 2008, as set forth in the Factual Findings above. Counsel for respondent implied in argument that if respondent did touch K.S., it was not sexual. Counsel pointed to a statement by K.S. that described respondent’s touch as a “poke,” and contended that there was no evidence that any

⁵ *In Re David C.* (1984) 152 Cal.App. 3d 1189, 1208.

touching was sexual. The contention lacks merit. There is no other plausible explanation for respondent asking K.S. if he could feel her breast and then doing so, or asking her if he could see her breast and then baring it and looking. The touch alone might be ambiguous enough, under the circumstances, to render the motivation for the touching ambiguous. But the totality of the circumstances clears away the ambiguity in favor of a clearly sexual motivation. Respondent did not just ask to touch and then did so. He asked to see K.S.'s breasts and then bared her chest by lifting her hospital gown. He lingered after the test in such a fashion that he made the victim feel even more awkward than she already did. He asked for a follow up look at her breasts after the surgery. The totality of the circumstances proved reveals the motivation for respondent's misconduct was indeed sexual.

5. The problem with counsel's contention was that respondent never endorsed the factual foundation for the claim. Respondent denied touching K.S. at all. He never distinguished between a sexually motivated touching and touching her for some other, nonsexual reason. He claimed K.S. initiated the conduct and he did not suggest in his claim that her conduct was anything other than sexual. In fact, he strongly inferred the opposite, making much in his testimony of his response to K.S. exposing her breasts to him by turning away and not looking. This last statement stood out as the least credible and persuasive of several serially unpersuasive statements. After his first interview by Ms. Santos and Mr. Sammons, where he ambiguously suggested late in his statement, in what appeared to be an afterthought, that his motivation for touching K.S.'s breasts might have been curiosity, he later adamantly denied any touching at all, regardless of motivation or intention.

6. A similar fate is required for counsel's contention in argument that there was no sexual conduct because the person performing an EKG "pokes his/her finger along the chest area to locate the appropriate placement of the leads. There is nothing sexual about this type of a poke, even if done in the wrong location." The argument fails because it was not supported by the evidence. Respondent made no such claim, even in his first interview with Ms. Santos and Mr. Sammons.

7. Respondent also contends that K.S.'s statement about respondent's misconduct is inherently implausible because she did not report the misconduct to anyone in authority at the hospital until several days later, when she became angry because she was not able to obtain her EKG and was worried she might not be able to have her surgery when scheduled. Counsel questions why K.S. failed to immediately report respondent's misconduct, were it true. He also suggests that if the misconduct occurred as K.S. reported, the fact that she was willing to allow herself to be alone with respondent again the very next day for another EKG makes no sense. Counsel suggests that K.S.'s failure to ask for a different technician to perform the follow up test, failure to return some other time to avoid respondent or failure to request a third person be present all make no sense if her report of the misconduct is accurate. He contends K.S. appeared more upset that her EKG could not be found than with respondent's misconduct.

8. Counsel's contention that all of the foregoing facts should be considered in weighing the credibility of K.S. is correct, and that weighing and assessing did occur, with due weight assigned to the points made by counsel. But K.S.'s testimony and statements, of which there were three, all consistent in all material respects, cannot be assessed in a vacuum, as the contention appears to suggest. It must be assessed against respondent's credibility in a relative fashion, since both described the same events, against respondent's previous statements, and against his demeanor and presentation relative to that of K.S. In all of these areas, respondent came up rather deficient and the call was not close.

9. K.S. was quite credible in her testimony, and her demeanor was persuasive and consistent with her reports of the incident. As set forth in the Factual Findings, respondent's credibility and persuasiveness was poor, his previous statements were not consistent, and his explanations for the discrepancies were manifestly unpersuasive, as was his wholly contrived explanation of the need for the second EKG, and what he did with the EKG reports and why. Respondent found himself tangled in a self-spun web of deceit, and K.S. did not.

10. Respondent's sexual misconduct occurred during and within the scope of respondent's assigned professional duties while employed as a respiratory care practitioner at Sutter Amador Hospital. Respondent contends that since respondent was not acting within his scope and capacity as a licensed RCP at the time of the misconduct, the Board "has no right to take away his RCP license because he was not acting as a RCP."

11. As set forth in the Factual Findings above, this contention is wholly lacking in merit. Mr. Sammons and the Board's expert both made clear that RCPs on hospital staffs are commonly called upon to perform EKGs as part of their duties. Respondent agreed, having performed "thousands" of such tests as part of his professional duties. The fact that performing this particular diagnostic test is not specifically enumerated in the non self-limiting description of the scope of RCP practice set out in Business and Professions Code section 3702 does not mean that respondent is exempt from discipline. The permissible scope of RCP practice on California is as much described by the standards of care in the RCP community in California as they are by statute or regulation. There is nothing in section 3702 that could be read to prohibit a properly trained RCP from performing an EKG, and there is language in the statute that suggests that RCPs assigned to perform diagnostic testing when properly trained are envisioned even in the statute.

12. Section 3702 reads, in pertinent part, as follows:

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:

(a) Direct and indirect pulmonary care services that are safe, aseptic, preventive, and restorative to the patient.

(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.

¶...¶

13. In addition, the contention seeks to avoid the fact that the Board's jurisdiction and authority to discipline a licensee extends to acts and omissions committed outside the actual practice setting, and may encompass acts and omissions unrelated to actual practice, as long as those acts are proved to be substantially related to the practitioner's fitness to practice, such as drug and/or alcohol abuse that is never evident in the workplace, a criminal conviction or a disciplinary action taken in another state. "For a nexus to exist between the misconduct and the fitness or competence to practice medicine, it is not necessary for the misconduct forming the basis for discipline to have occurred in the actual practice of medicine. '[The Medical Board] is authorized to discipline physicians who have been convicted of criminal offenses not related to the quality of health care.'"⁶ This action is well within the Board's regulatory authority and jurisdiction.

14. Respondent's sexual misconduct while performing his professional duties constitutes the commission of a corrupt act that is substantially related to his duties as a RCP with Sutter Amador, within the meaning of section 3750, subdivision (j). Legal cause exists to revoke or suspend respondent's respiratory care license.

Second Cause For Discipline

15. In the Second Cause for Discipline in the Accusation, it is alleged that respondent was negligent (violation of section 3750, subdivision (f)) and incompetent (violation of subdivision (o) of the same section. No expert testimony was offered that commission of inappropriate sexual touching in the course of performing an EKG constituted conduct beneath the standard of care or was incompetent.

16. Evidence Code section 801 provides that expert opinion testimony is only admissible if it relates to a subject that is sufficiently beyond common experience that the opinion of an expert would assist the trier of fact. The need for expert testimony regarding

⁶ *Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 770 (physician suffered three DUI convictions but no evidence of alcohol related behavior or impairment in his medical practice), citing *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal. App. 3d 1471, 1476, *Hughes v. Board of Architectural Examiners* (2000) 17 Cal.4th at 788 (exceptionally skillful and well qualified architect disciplined for dishonesty on other states).

proof of the standard of care is the general rule, but the law relaxes the general rule where the conduct required by the particular circumstances is within the common knowledge of a lay person; where a lay person is able to say as a matter of common knowledge and observation that the consequences of professional treatment were not such as would have ordinarily occurred had due care been exercised.⁷ This rule has been repeatedly followed, where the professional conduct is such that a lay person exercising common judgment and experience, does not need expert opinion to identify the conduct as such as would not have occurred absent failure to exercise due care.⁸ This rule has been applied to sexual misconduct between a licensed professional and a patient.⁹ The application of the standard set forth in Evidence Code section 801 clearly leads to this result. It is certainly within the common layperson's experience that having an EKG performed in a hospital by a licensed professional should never include unsolicited groping of the patient's private parts during the procedure. Sexual misconduct is never part of professional medical treatment, including the most basic testing procedures, and no expert opinion is required for reaching that conclusion.

17. Therefore, respondent's sexual misconduct while he was performing the EKG on K.S. was negligent, within the meaning of section 3750, subdivision (f), in that it constituted conduct beneath the standard of care for a RCP performing an EKG.

18. On the other hand, there was no evidence that respondent's sexual misconduct constituted an exhibition of such a deficit of education, training or experience as a RCP that it can be concluded that he was incompetent in the performance of his duties. Incompetence "generally indicates 'an absence of qualification, ability or fitness to perform a prescribed [professional] duty or function.'"¹⁰ "Incompetence is distinguishable from negligence, in that one 'may be competent or capable of performing a given duty but negligent in performing that duty.' Thus, 'a single act of negligence...may be attributable to remissiveness in discharging known duties, rather than...incompetency respecting the proper performance.'"¹¹ There was no evidence that respondent was deficient in training, education or experience as a RCP. In fact, the evidence was quite the contrary. No amount of education, training or experience correlates to the problem respondent experienced on April 10, 2008; failure of good judgment and common sense in his failure to control his lust and his impulses.

⁷ *Franz v. Board of Medical Quality Assurance* (1982) 31 Cal.3d 124, 141, *Cobbs v. Grant* (1972) 8 Cal.App. 3d 229, 236.

⁸ *Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.App.4th 992, 997-98 (Emergency room patient was placed on a gurney without being secured, patient fell asleep, fell off while asleep and was hurt), *Leonard v. Watsonville Community Hospital* (1956) 47 Cal. App.2d 509, 514 (surgeon left a clamp in patient's body and closed surgical site) *Ybarra v. Spangard* (1944) 25 Cal.2d 486, 488-90 (patient sustained a shoulder injury during appendectomy surgery).

⁹ *Cooper v. Board of Medical Quality Assurance* (1975) 49 Cal. App.3d 931, 974 (held no expert witness required to prove psychologist having sex with a patient was beneath the standard of care.)

¹⁰ *Kearl v Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1054-55, citing *Pollack v. Kinder* (1978) 85 Cal.App.3d 833, 837.

¹¹ *Id.*, citing *Peters v. Southern Pacific Co.* (1911) 160 Cal. 48, 62.

Third And Fourth Cause For Discipline

19. The Accusation alleges in the Third Cause for Discipline that respondent was negligent and incompetent for requiring K.S. to have to submit to a second, unnecessary EKG and destroying the record of the second EKG. The Fourth Cause for Discipline alleges the same conduct was a fraudulent, dishonest or corrupt act, within the meaning of section 3750, subdivision (j).

20. Respondent's conduct in causing K.S. to submit to a second EKG can only be interpreted one of two ways. Either he was negligent and incompetent, or he used the second EKG as a pretext to assess whether K.S. would either warm to his earlier misconduct and/or the likelihood that she might report him for his misconduct the day before. There was considerable undisputed evidence that respondent was competent to perform EKGs, and had performed "thousands" of these tests and "hundreds" of stress EKGs under the supervision of a cardiologist. There was no reason to believe, and the evidence tended to confirm this, that respondent was not well aware that the EKG machine he was using would issue a warning and note the invalidity of any test on the report if the leads were incorrectly placed or crossed. Respondent's testimony regarding why he caused K.S. to take the second EKG was so lacking in credibility that it is accordingly equally difficult to place any credence in any allegation that his causing the second EKG to be performed was the product of his negligence or incompetence. Rather, it was clear that he caused the second test to be performed for a dishonest and corrupt reason, to it, to assess K.S.'s reaction to his sexual misconduct toward him the day before. Therefore, it was not proved that respondent's conduct in requiring K.S. to submit to a second, unnecessary EKG and then destroying the test report was negligent or incompetent, within the meaning of section 3750, subdivisions (f) or (o). However, it was proved that respondent's conduct constituted a dishonest and corrupt act, within the meaning of section 3750, subdivision (j).

Fifth Cause For Discipline

21. The Fifth Cause for Discipline alleges the conduct found true above constitutes unprofessional conduct, within the meaning of section 3755.

22. Business and Professions Code section 3755 provides,

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. (Italics added)

23. Respondent again contends the Board lacks authority to impose disciplinary action on him because he was not acting within the scope of respiratory care practice at the time of his misconduct. He contends he was acting as an EKG technician at the time, performing no duties for which a respiratory care license is required. He points to the testimony of respondent's supervisor and the Board's expert, both of whom confirmed that no particular license is required to perform an EKG, that any licensed healthy care professional working in a hospital setting can and often is called upon to perform these tests, and that therefore, he is being singled out unfairly for discipline. He contends he should be treated as an EKG technician would for the same behavior.

24. These contentions fail for the same reasons they did for the earlier allegations set forth above. Respondent was actively engaged in professional duties at a staff RCP at Sutter Amador Hospital. Although performing an EKG can be accomplished by any properly trained licensed professional or technician, the Sutter Amador, as does many California hospitals, has RCPs perform EKGs as part of their professional duties. Respondent was acting within the course and scope of his professional duties at the time he engaged in the misconduct set forth above. Respondent's behavior constituted unprofessional conduct, within the meaning of section 3755. Legal cause therefore exists to revoke or suspend respondents RCP license.

Sanction

25. The license revocation procedure is designed to protect the public, not to administer punishment to individual licensees.¹² "The object of an administrative proceeding aimed at revoking a license is to protect the public, that is, to determine whether a licensee has exercised his privilege in derogation of the public interest, and to keep the regulated business clean and wholesome."¹³ The purpose of an administrative proceeding concerning the revocation or suspension of a license is not to punish the individual; the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners.¹⁴

26. The determination of an appropriate penalty for the violations proved is a matter of weighing the gravity of the violations and any facts in aggravation against any facts in mitigation or rehabilitation. Mindful of the consequences of putting someone out of one's chosen vocation who has been licensed and practiced for more than three decades in a poor economy, the sanction for the violations proved is a matter of serious consequence requiring careful consideration.

¹² *Ettinger v. Board of Medical Quality*, supra, 135 Cal.App.3d at p. 856.

¹³ *Id.*, quoting *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.

¹⁴ *Ettinger*, supra, at 856, quoting *Meade v. State Collection Agency Board* (1960) 181 Cal.App.2d 774, 776 and *West Coast Co. v. Contractors' Board* (1945) 72 Cal.App.2d 287, 301-302.

27. The facts in mitigation were respondent's long record of licensure without evident complaint or disciplinary action. The sexual misconduct was not egregious or prolonged, and she did not sustain physical injury, which helps explain why K.S. did not report respondent's behavior immediately. But it would be inaccurate to contend that little harm was done, even though K.S. did not suffer any physical injury. The personal sanctity of K.S. body was violated by being groped, and her trust in both respondent as a health care provider and the health care profession generally was betrayed. Respondent crossed a bright line of trust that must remain inviolate if health care is to retain any credibility as a safe place for patients to seek diagnosis and treatment, and where female patients' rights to receive treatment free from fear of being groped in the process is to be observed. Even while performing a diagnostic test as innocuous as an EKG, the health care professional is held to a higher standard of faithfulness, honesty and integrity toward patients than many other professionals, because those patients are uniquely and exceptionally vulnerable during treatment, exposed and supremely at risk for precisely the sort of taking advantage that respondent engaged in here. In the treatment setting, and especially in a private treatment room, the patient is forced to place a level of trust in health care professionals higher than required for many other professionals rendering services to the public.

28. There are no facts in rehabilitation. In aggravation, respondent lied about his conduct to his employer and to this tribunal. Respondent does not acknowledge he engaged in the misconduct. Thus, there can be no rehabilitation, as there is no remedy for a problem not acknowledged. Respondent's clean record for more than three decades stands against a major breach of the inviolate trust relationship between patient and care provider, where respondent exhibited character flaws of significance, including exceptionally poor judgment, failure to control his impulses and lust, and dishonesty about his subsequent conduct. Respondent failed to evidence suitability for probationary supervision, as there is no way in a probationary order to address successfully and in a manner that insures public protection the behavior and conduct choices exhibited by respondent that resulted in the violations of law. Further, his untruthfulness to his employer when the inquiry was being made into his conduct bodes poorly for his amenability to probationary supervision which, by its nature, relies to a great deal upon the honesty and trustworthiness of the probationer with little effective oversight. Respondent failed to exhibit any insight into the nature of the problem and its consequences. Respondent's choices regarding his conduct with K.S. and its aftermath removed any other penalty options but revocation.

29. Business and Professions Code section 3753.1 provides;

- (a) An administrative disciplinary decision imposing terms of probation may include, among other things, a requirement that the licensee-probationer pay the monetary costs associated with monitoring the probation.
- (b) The board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section once a licensee has served his or her term of probation.

30. The Board may request the Administrative Law Judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case under Business and Professions Code section 3753.5. Business and Professions Code section 3753.7 provides: For purposes of this chapter, costs of prosecution shall include attorney general or other prosecuting attorney fees, expert witness fees, and other administrative, filing, and service fees.

Zuckerman v. Board of Chiropractic Examiners (2002) 29 Cal.4th 32, requires the consideration of the following factors in determining the amount of costs to be assessed:

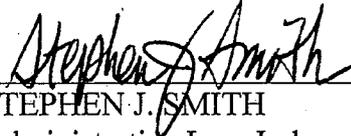
- The board must not assess the full costs of investigation and prosecution when to do so will unfairly penalize a licensee who has committed some misconduct, but who has used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed.
- The board must consider the licensee's subjective good faith belief in the merits of his or her position.
- The board must consider whether the licensee has raised a colorable challenge to the proposed discipline.
- Furthermore, as in cost recoupment schemes in which the government seeks to recover from criminal defendants the cost of their state-provided legal representation, the board must determine that the licensee will be financially able to make later payments.
- Finally, the board may not assess the full costs of investigation and prosecution when it has conducted a disproportionately large investigation to prove that a licensee engaged in relatively innocuous misconduct.

32. The *Zuckerman* factors were carefully considered in this matter. The Board prevailed on the factual and legal allegations in a vigorously contested case. However, as set forth in the Factual Findings and in the final *Zuckerman* factor quoted above, the costs claim reflects a disproportionately large amount of time and money relative to the amount of investigation and preparation reasonably required for a case that came to the Board almost fully investigated by outside agencies. There was no evidence presented of details for the time and costs incurred, and no explanation to counter the evidence that Sutter Amador Hospital and the Amador County Sheriff conducted complete investigations that the Board could adopt in full. Considering the dearth of supporting detail offered in support of the costs recovery claim, awarding \$5000.00 is generous under the circumstances and is determined to be a reasonable amount for the investigation and enforcement activity as evaluated by the *Zuckerman* factors and the nature and circumstances of this case.

ORDER

Respiratory Care Practitioner License number 755, issued by the Respiratory Care Board to Albert Dale Beith, R.C.P., is REVOKED.

DATED: March 22, 2010

A handwritten signature in black ink, appearing to read "Stephen J. Smith", is written over a horizontal line.

STEPHEN J. SMITH
Administrative Law Judge
Office of Administrative Hearings