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

In the Matter of the Accusation Against: ) Case No. 10-2007-186525
) OAH No: 2009101371
MAURICE BUCHBINDER, M.D. )
) Physician’s & Surgeon’s Certificate No. A 38176 )
) Respondent. )

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby accepted and adopted as the Decision and Order by the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on April 12, 2010.

ORDERED March 10, 2010

MEDICAL BOARD OF CALIFORNIA

Shelton Duruisseau, Ph.D.
Panel A Chair
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PROPOSED DECISION


Matthew M. Davis, Deputy Attorney General, Department of Justice, State of California, represented complainant Barbara Johnston, the Executive Director of the Medical Board of California, Department of Consumer Affairs, State of California.

Kenneth J. Medel, Attorney at Law, represented respondent Maurice Buchbinder, M.D., who was present throughout the administrative hearing.

The matter was submitted on January 25, 2010.

INTRODUCTION

Dr. Maurice Buchbinder is a highly skilled interventional cardiologist who practices in San Diego. On August 24, 2007, in the Cath Lab at Scripps Memorial Hospital, Dr. Buchbinder performed a cardiac catheterization upon Richard M., an opioid dependent 68-year-old patient with a history of myocardial infarction and acute coronary disease.

During the procedure, Richard M. became very agitated and combative. Additional medications were administered, Dr. Buchbinder and the Cath Lab staff physically restrained Richard M., and Dr. Buchbinder completed the interventional procedure. Several Cath Lab staff members believed Dr. Buchbinder used excessive force and made inappropriate remarks to the patient during the procedure. After Richard M. was placed on a transfer gurney, Dr.
Buchbinder had further verbal and physical interaction with the patient which some Cath Lab staff members found quite disturbing.

Dr. Buchbinder contended that his conduct in the Cath Lab was appropriate and necessary, that he used only the amount of force that was required to protect the patient, and that his interactions were always professional.

Dr. Buchbinder conceded that he had some anger issues in the past, although never with patients, and he claimed that he had resolved those issues through therapy. Dr. Buchbinder asserted that he does not present any danger to the public.

PRIMARY ISSUES

Did Maurice Buchbinder, M.D. engage in unprofessional conduct in the care and treatment of Richard M. by having the patient undergo an angioplasty when the patient’s cardiac condition did not warrant an interventional procedure without first obtaining a further diagnostic assessment; by failing to obtain an anesthesia consult before the catheterization procedure began or by failing to call for anesthesia during the procedure when the patient became agitated; by causing a narcotic reversal agent to be administered when doing so was contraindicated; and/or by using excessive physical force and making improper comments to the patient during and after the procedure?

If grounds for discipline exist, what measure of discipline, if any, is required to protect the public?

FACTUAL FINDINGS

Jurisdictional Matters

1. On August 13, 2009, complainant Barbara Johnston, the Executive Director of the Medical Board of California (the Medical Board), Department of Consumer Affairs, State of California, signed Accusation Case No. 10-2007-186525. The accusation and other required jurisdictional documents were served on respondent Maurice Buchbinder, M.D. (Dr. Buchbinder or respondent), who timely filed a notice of defense.

On January 11, 2010, the record in the disciplinary matter was opened, jurisdictional documents were presented, and opening statements were given. On January 11-14, 19-21, and 25, 2010, sworn testimony was provided, documentary evidence was received, and official notice was taken of the Medical Board’s disciplinary guidelines. On January 25, 2010, closing arguments were given, the record was closed, and the matter was submitted.
License History

2. On March 22, 1982, the Medical Board issued Physician’s and Surgeon’s Certificate No. A 38176 to Dr. Buchbinder. That certificate is in full force and effect. It is renewed through June 30, 2011. There is no history of any previous administrative discipline having been imposed against Dr. Buchbinder’s certificate.

Dr. Buchbinder’s Background, Education, Training and Experience

3. Dr. Buchbinder was born in 1953 in Lebanon. His father was a physician and his mother was a homemaker. He is the oldest of three sons. As a result of the turmoil in Lebanon, Dr. Buchbinder’s parents arranged for him to live to Montreal, Canada, when he was a teenager. Dr. Buchbinder lived in Canada by himself and graduated from high school.

After high school, Dr. Buchbinder attended McGill University in Montreal, where he received a bachelor’s degree in biology in 1974. He then attended medical school at McGill University, where he received a medical degree in 1978. Dr. Buchbinder completed an internship and junior residency at McGill University in 1980.

Dr. Buchbinder completed a senior residency in Internal Medicine and a Fellowship in Cardiology at Stanford University Hospital in 1983, where he developed a passion for interventional cardiology. Dr. Buchbinder served as an Assistant Clinical Professor of Medicine, Department of Cardiology, at Stanford University from 1983 through 1985, when he also was a staff physician at the Palo Alto VA Hospital.

Dr. Buchbinder became board certified in Internal Medicine in 1981, and he was board certified in Cardiology in 1983.

Dr. Buchbinder was recruited by the UCSD Medical Center. In 1985, he moved to San Diego, where he became a Professor of Medicine, Cardiology Division, UCSD Medical School. Dr. Buchbinder was one of the individuals responsible for developing UCSD’s Cardiac Cath Lab. In 1990, Dr. Buchbinder became an Associate Professor of Medicine at UCSD. He remained on the staff at the UCSD Medical Center through 1995. About 80 percent of Dr. Buchbinder’s time at UCSD was spent doing procedures in the Cath Lab, where he performed approximately five to seven interventional procedures a day.

In 1995, Dr. Buchbinder established the Foundation for Cardiovascular Medicine, a non-profit organization that engages in clinical research and provides education in the field of coronary artery disease. In 1997, Dr. Burchbinder became the Medical Director of Radiance Medical Systems, Inc., an entity that developed and marketed coronary radiation delivery catheters and other medical devices. Dr. Buchbinder was associated with Radiance through 2003. Dr. Buchbinder holds 13 patents related to cardiac catheterization devices.

In 1995, Dr. Buchbinder joined San Diego Cardiovascular Associates, a group of cardiologists practicing in San Diego County. From 1995 through 1999, Dr. Buchbinder served as the Director of the Interventional Cardiology Department at Sharp Memorial
From 1995 through 2007, he was the Director of Interventional Cardiology at Scripps Memorial Hospital (Scripps). When he had staff privileges at Scripps, Dr. Buchbinder performed about 1,000 cardiac catheterizations per year.

4. Following the August 2007, Cath Lab incident which gives rise to this disciplinary proceeding, Dr. Buchbinder’s staff privileges at Scripps were summarily suspended pending further investigation. Dr. Buchbinder resigned from the staff at Scripps in September 2007. Dr. Buchbinder’s privileges at Scripps have not been restored.

5. In December 2007, Dr. Buchbinder obtained staff privileges at Alvarado Hospital in San Diego, and he thereafter obtained staff privileges at Paradise Valley Hospital in National City.

6. Dr. Buchbinder enjoys the reputation of being a highly skilled interventional cardiologist. He has lectured in the areas of acute coronary artery disease and interventional cardiology throughout the world. Dr. Buchbinder has published numerous scholarly articles regarding his medical specialty. He has developed several medical devices.

Dr. Buchbinder testified that he had performed approximately 25,000 cardiac catheterizations over the course of his career.

Cardiac Catheterization

7. Notice is taken of the following matters. Cardiac catheterization involves the insertion of a thin flexible tube (catheter) into a chamber or vessel of the heart. The procedure is performed for both investigational and interventional purposes. Coronary catheterization involves the catheterization of the coronary arteries.

To begin the procedure, a local anesthetic is injected into the skin to numb the area where the catheter will be introduced. A small puncture is then made with a needle, most often in the femoral artery in the groin, after which a guidewire is inserted into the arterial puncture. A plastic sheath (with a stiffer plastic introducer inside it) is then threaded over the wire and is pushed into the artery. The wire is then removed. The sheath remains in place.

Catheters are inserted through the sheath using a long guidewire and are moved towards the heart. The guidewire is removed once the catheter in position. The catheter then engages the origin of the coronary artery, and an x-ray opaque iodine-based contrast is injected to make the coronary vessels show up on x-ray fluoroscopy.

Angiography and arteriography are the terms used to describe the imaging technique used to visualize the inside, or lumen, of blood vessels. Investigation may be performed to confirm the presence of a suspected heart ailment, to quantify the severity of the disease and its effect on the heart, to seek out the cause of a symptom such as shortness of breath, pain or any other sign of cardiac insufficiency, and to make an assessment before conducting additional procedures. Arteriography is the gold standard in diagnosing the presence and extent of coronary artery disease.
Percutaneous coronary intervention (PCI), commonly known as coronary angioplasty, is a term that describes a therapeutic procedure to treat stenotic (narrowed) coronary arteries. Angioplasty is usually performed by an interventional cardiologist. Angioplasty involves interventional techniques to mechanically widen a narrowed or obstructed blood vessel. An interventional cardiologist may use one or more interventional procedures or techniques when performing angioplasty. Common interventions include:

**Balloon angioplasty:** During this procedure, a specially designed catheter with a small balloon tip is guided to the point of narrowing in the artery. Once in place, the balloon is inflated to compress the fatty matter into the artery wall and to stretch the artery open to increase blood flow to the heart.

**Stenting:** A stent is a small metal mesh tube that acts as a scaffold to provide support inside a coronary artery. A balloon catheter is used to insert the stent into the narrowed coronary artery. Once in place, the balloon tip is inflated and the stent expands to the size of the artery and holds it open. The balloon is then deflated and removed, while the stent stays in place. Over a several-week period, the artery heals around the stent. Some stents, known as drug-eluding stents, contain medicine and are designed to reduce the risk of reblockage (restenosis).

**Rotablation:** A special catheter with a diamond-coated tip is guided to the point where the coronary artery narrows. The tip spins around at a high speed and grinds away the plaque on the artery wall. The microscopic particles are washed away in the bloodstream and are filtered from the body through the liver and spleen. This process is repeated as needed to allow for better blood flow. Rotablation is rarely used today because balloon angioplasty and stenting have yielded much better results and are technically easier to perform.

When the necessary diagnostic and interventional procedures are completed, the catheter and indwelling sheath are removed. Firm pressure must be applied to the femoral puncture site to prevent bleeding. The pressure required to close the wound may be applied by hand or through the use of an angioseal. The patient is usually required to lie flat for several hours after a procedure to prevent bleeding.

8. Conscious sedation is commonly used during routine cardiac catheterizations. Conscious sedation induces an altered state of consciousness that minimizes a patient’s anxiety, pain and discomfort through the appropriate use of pain relievers and sedatives. The patient maintains an unassisted airway during the procedure. A patient who receives conscious sedation is usually able to speak and respond to verbal cues and commands, expressing any discomfort and following directions. Monitoring equipment must be in place to check the patient’s blood pressure, pulse, respiratory rate, level of consciousness, and, most importantly, oxygen saturation. An anesthesiologist need not be present during conscious sedation, but the presence of a trained and qualified provider is required.
9. During cardiac catheterization, the patient undergoing the procedure is expected to remain still and flat on the catheterization table, and to cooperate with health care providers. It is rare that a patient becomes highly agitated during a cardiac catheterization, but if that occurs, several serious risks of injury accompany agitation and patient movement including contamination of the sterile field, migration of the coronary wires and the puncture of a coronary artery and the possibility of a cardiac tamponade, and the unintended removal of the sheath from the femoral artery which may result in the patient bleeding out or developing a retroperitoneal hematoma.

Dr. Buchbinder and the Scripps Cath Lab Staff

10. Although Dr. Buchbinder got along well with his patients and their families, he and the Cath Lab staff at Scripps did not get along so well. He was a perfectionist. Dr. Buchbinder was very full of himself, hard on the staff, and relatively inflexible in his demands. He frequently belittled Cath Lab staff and rarely praised their efforts. He did not care about the considerable ill will he created.

Cath Lab staff and others complained about Dr. Buchbinder, which resulted in the Scripps Medical Executive Committee (the MEC) directing Dr. Buchbinder to undergo a psychiatric evaluation by Robert Nemiroff, M.D. Dr. Nemiroff, a psychiatrist, first met with Dr. Buchbinder in March 2003. After several sessions, Dr. Nemiroff sent a letter to the MEC dated May 30, 2003, in which he communicated his belief that Dr. Buchbinder was open to change and that he and Dr. Buchbinder had reached certain conclusions:

“1. Given the nature of cardiac interventionist work, we have been able to identify a pattern, when an anxiety arises and Dr. Buchbinder feels momentarily out of control. In the past, he has attempted to reestablish control by some passionate exchange with staff that is interpreted as anger by staff which leads to bad feelings by all concerned and possible unintended consequences. Dr. Buchbinder has now been able to better identify these anxiety situations which turn into instant ‘anger expressions,’ this is not completely ‘perfect’ as yet, he reports considerably more success in being able to respond in a calmer, more appropriate way. 2. Related to the above issue is Dr. Buchbinder’s relationship with staff and colleagues. In the past, he has regarded excellent patient care as his primary value and goal as a physician. Of course, it still remains as his top priority but during our meetings, he has come to see that care for the self-esteem and careers of the people he works with is also an important value and not necessarily mutually exclusive from his patient care values. In fact, he now realizes that the more he can improve the morale of the staff, the more likely it is that his primary goals of superior patient care will be met . . . With the staff he is now attempting to adopt a more educational approach, sharing with them his extensive cardiac knowledge in an attempt to foster this new collegial, less judgmental approach. . . .”

Dr. Nemiroff warned the MEC that Dr. Buchbinder might have some behavioral slips in the future, but notwithstanding this possibility, Dr. Nemiroff believed that Dr. Buchbinder was devoted to and capable of changing his maladaptive behavior.
Correspondence from the MEC to Dr. Buchbinder following his visits with Dr. Nemiroff in 2003 suggested that Dr. Buchbinder improved his relationship with hospital staff. However, in January 2004, it was suggested that Dr. Buchbinder see Dr. Nemiroff again after it was reported that Dr. Buchbinder had screamed at another colleague over a scheduling misunderstanding. Dr. Buchbinder declined that invitation without consequence.

In June 2006, Dana Launer, M.D. (Dr. Launer), Scripps Chief of Staff, met with Dr. Buchbinder and directly warned him that his continued behavioral problems with the Cath Lab staff jeopardized his directorship of the Cath Lab, and endangered his membership on the Scripps medical staff. According to Dr. Launer, Dr. Buchbinder took responsibility and expressed remorse. Again, no real consequences were imposed.

In his testimony in this disciplinary hearing, Dr. Buchbinder testified that he had substantial interpersonal problems with some Scripps staff members, that he “may have been too vocal” with staff members and that he “may have hurt their feelings” on occasion. He described himself as a short-tempered perfectionist who sometimes became frustrated and angry when his expectations were not met. Dr. Buchbinder understated the case.

Throughout his difficult tenure at Scripps, there was never any assertion that Dr. Buchbinder engaged in inappropriate or hostile interactions with patients or their families.

Standard of Care

11. The standard of care requires a medical professional to possess and exercise that level of knowledge and skill ordinarily possessed by members in good standing in his specialty. A physician must use reasonable diligence to accomplish the purpose for which he was employed. A failure to fulfill any such duty is negligence.

A physician is not necessarily negligent because he errs in judgment or because his efforts prove unsuccessful. The physician is negligent only if his error in judgment or lack of success is due to a failure to perform within the standard of care. Where more than one accepted method of diagnosis or treatment is established by expert testimony, and no method of treatment is used exclusively and uniformly by all reputable practitioners in the same or similar circumstances, a physician is not negligent if in exercising his best judgment, he selects an approved method which later turns out to be wrong or not favored by other practitioners.

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12. The standard of care must be established by expert testimony.\textsuperscript{5} It is often a function of custom and practice.\textsuperscript{6} Expert testimony is not admissible to show that a standard of care should have been different, nor is an expert permitted to second-guess an entire profession.\textsuperscript{7} The process of deriving a standard of care necessarily requires some evidence of an ascertainable practice.\textsuperscript{8}

*Negligence, Gross Negligence, Repeated Negligent Acts*

13. Simple or ordinary negligence consists of a failure to exercise the degree of care in a given situation that a reasonable person under similar circumstances would employ to protect others from harm. “Gross negligence” long has been defined in California as either a “want of even scant care” or “an extreme departure from the ordinary standard of conduct.”\textsuperscript{9}

Repeated negligence involves two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care constitutes a repeated negligent act. An initial negligent diagnosis followed by an act or omission that is medically appropriate for that negligent diagnosis constitutes a single negligent act. When the standard of care requires reevaluation of a diagnosis or a change in treatment, and the physician’s conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.\textsuperscript{10}

*Patient Richard M.*

14. Patient Richard M. was born in January 1939. Richard M. was a successful physicist and engineer who developed significant heart problems in the early 1990s.

In June 1991, Richard M. presented to UCSD with chest pain. A myocardial infarction was ruled out. On stress testing there were no ECG changes, but Richard M. failed to reach the targeted heart rate and further testing suggested an anterior and inferior restriction of the blood supply.

In July 1991, Richard M. presented at Scripps Memorial Hospital with an acute inferior wall myocardial infarction. Richard M. underwent a salvage angioplasty with a good result and he was discharged on medications.


\textsuperscript{9} *City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 753-754.

\textsuperscript{10} Business & Professions Code section 2234, subdivision (c).
In August 1991, Richard M. suffered more chest pain and was readmitted to the hospital. An attending cardiologist evaluated Richard M. and referred him to Dr. Buchbinder for a diagnostic angiogram. On August 5, 1991, Dr. Buchbinder performed a diagnostic angiogram at UCSD, where Dr. Buchbinder was then practicing. Following that procedure, Dr. Buchbinder recommended Richard M. remain on Coumadin for three months before undergoing additional testing.

In July 1992, Richard M. returned with a several-week history of intermittent episodes of chest pain. He was admitted to Scripps, was seen by several physicians, and underwent a left heart catheterization performed by someone other that Dr. Buchbinder. That catheterization revealed a 70 percent narrowing of the proximal right coronary artery which was stented. Richard M. was released from the hospital and remained on Coumadin after that procedure.

Richard M.'s August 2007 Catheterization

15. On the afternoon of August 23, 2007, Richard M. experienced chest pain at home that was unrelieved with medication, some dizzy spells, nausea, and a rapid heart rate (tachycardia). Paramedics transported Richard M. to Scripps Memorial Hospital, where he was evaluated in the emergency room. Richard M.'s medical history now included emphysema, a myocardial infarction, a Methicillin-resistant Staphylococcus aureus infection (MRSA, a bacterial infection highly resistant to antibiotics), questionable atrial fibrillation, a pacemaker placement and cardiac stenting. The emergency room physician examined Richard M., administered various medications, including morphine and 100 mcg IV Fentanyl for ongoing chest pain. Richard M. specifically asked the emergency room physician to contact Dr. Buchbinder, who was not on call that evening.

The emergency room physician contacted Dr. Buchbinder, who was at home. Dr. Buchbinder agreed to assume Richard M.'s care. Dr. Buchbinder left home and went to Scripps, where he met with Richard M. At first, Dr. Buchbinder did not recall Richard M., whom he had not seen in many years, but he ultimately recalled treating Richard M.

Dr. Buchbinder completed a handwritten progress note dated August 23, 2007, at 8:00 p.m. In part, the admission note stated that the patient had experienced severe 7 out of 10 chest pain with associated supraventricular tachycardia earlier that day, and that his pain resolved after he arrived at the hospital. Laboratory tests did not show elevated cardiac markers. The note stated that the patient had a complex medical history with "chronic osteomyelitis (MRSA) treated with antibiotics" in the past year, COPD, and "chronic back pain on Fentanyl11 patch and oral Dilaudid12." Richard M.'s last interventional procedure

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11 Notice is taken that Fentanyl - brand names include Actiq, Durogesic, Duragesic, Fentora, Onsolis, and Sublimaze - is a synthetic primary opioid receptor agonist commonly used to treat chronic breakthrough pain and in pre-surgical procedures. It is approximately 100 times more potent than morphine. After successful clinical trials, Duragesic Fentanyl patches were introduced. Following the patch, a flavored Fentanyl lollipop was introduced under the brand name of Actiq, for use with chronic breakthrough pain.
was in 2001. Dr. Buchbinder’s plan was to rule out acute coronary artery disease, to maintain Richard M. on his current medical regimen, and to have Richard M. seen the following day in the Cath Lab.

At the time of Richard M.’s 2007 admission, Dr. Buchbinder thought it likely that Richard M. was opioid dependent; indeed, he did not recall treating any other patient who consumed the same amount of prescribed pain medications on a daily basis as Richard M. Dr. Buchbinder was familiar with the concept of opioid withdrawal, and in his clinical practice before August 2007, he had performed cardiac catheterizations without complication for 10 to 15 patients who were undergoing opioid withdrawal.

16. Richard M. was Dr. Buchbinder's last scheduled patient in the Cath Lab on August 24, 2007. The evening before the procedure, Diane Wilkerson (Nurse Wilkerson), a Licensed Nurse Practitioner employed by the Foundation for Cardiovascular Medicine and one of Dr. Buchbinder's most trusted colleagues, wrote medication orders. The following morning, Nurse Wilkerson met with Richard M. and reviewed his current medications. Nurse Wilkerson then contacted Richard M.’s pain management specialist at UCSD and confirmed that the medication orders she had written for Richard M. were appropriate and current. The UCSD pain management specialist confirmed the amount of medications Richard M. was taking. The UCSD pain management specialist did not recommend that he consult with Dr. Buchbinder preoperatively. Nurse Wilkerson spoke with Dr. Buchbinder and relayed the information she had been given. Dr. Buchbinder reasonably assumed that Richard M. was receiving his normal doses of pain medications.

17. The Cath Lab staff scheduled to perform the August 24 procedure included Dr. Buchbinder, who served as the diagnostic and interventional cardiologist; Lori Jolley, RN (Nurse Jolley), who served as the primary nurse; Lance Reeter, CVT (Reeter), who served as the scrub technician; Jim Adams (Adams), a radiology technician, who served as the circulator; Ken Yeager, CVT (Yeager), who served as the monitor; and Juan Bribiesca, who served as the perfusionist.

18. An event log was maintained for the catheterization procedure.\textsuperscript{13}

The event log showed that Richard M. was on the table in the Cath Lab without chest pain at 3:20 p.m. but that he complained of back pain and provided a history of chronic back pain and MRSA, that there were no open wounds, and that isolation procedures were in place.

\textsuperscript{12} Notice is taken that Dilaudid is a potent centrally-acting analgesic drug of the opioid class. It is a derivative of morphine.

\textsuperscript{13} The times referred to hereafter were set forth in the event log maintained by the monitor. Dr. Buchbinder conceded that while the times in the procedure log might be somewhat inaccurate, he had no other method by which a more accurate schedule could be established.
At 3:22 p.m., the Cath Lab staff prepped and draped Richard M. in the usual manner. Richard M. said he understood the proposed procedure.

Richard M. was given 50 mcg of Fentanyl for pain and one mg of Versed\textsuperscript{14} IV for sedation at 3:31 p.m. He was assessed at 3:33 p.m. and there were no problems. Conscious sedation was initiated, after which Richard M. moved all four extremities upon command. He was able to breathe deeply and cough freely, his blood pressure was appropriate, he was fully awake, and his oxygen saturation was maintained at 92 percent on room air. Dr. Buchbinder reentered the Cath Lab and the diagnostic procedure began.

The left coronary system was injected and multiple views were obtained around 3:46 p.m. Another 50 mcg of Fentanyl was administered IV at 3:46 p.m. The catheter was removed and was reinserted with a guidewire, and the right coronary system was injected and multiple views were obtained around 3:48 p.m. Another 50 mg of Fentanyl was administered IV at 3:52 p.m. The catheter was removed and was reinserted by guidewire at 3:53 p.m. The catheter was removed at 3:55 p.m. There were no difficulties during the diagnostic procedure.

Dr. Buchbinder concluded, based upon the anatomy he observed during the diagnostic procedure, that there was a 70 to 80 percent blockage of the circumflex, a 70 to 80 percent blockage of the right coronary artery, and that angioplasty was indicated. 

\textit{Adherence to the Standards of Care}

\textbf{The Interventional Procedure:}

19. At 3:56 p.m., the interventional procedure began. Dr. Buchbinder inserted a stent balloon at 4:00 p.m. into the right circumflex. The stent balloon was removed and a PTCA (percutaneous transluminal coronary angioplasty) balloon was inserted at 4:01 p.m. After being inflated, that balloon was removed at 4:02 p.m. At 4:03 p.m., 50 mcg of Fentanyl and one mg of Versed were given IV. Nitroglycerin was given at 4:04 p.m.

At 4:06 p.m., Dr. Buchbinder began placing a stent in the right coronary artery. It was around this time, according to Dr. Buchbinder, that Richard M. complained of chest pain and began fidgeting and moving about the procedure table. Dr. Buchbinder directed that 100 mcg of Fentanyl be given IV to calm the patient.

An interventional guidewire was inserted into the patient's right coronary artery at 4:08 p.m. and a stent balloon was inserted at 4:10 p.m. The stent was deployed at 4:11 p.m. and the stent balloon was removed at 4:12 p.m. During this part of the procedure, the patient became increasingly uncooperative and restless. Richard M. was yelling, screaming about pain, and he was thrashing about on the table. At 4:13 p.m., a nurse administered 10 mg of Fentanyl.

\textsuperscript{14} Notice is taken that Versed is the brand name for Midazolam, an ultra short-acting benzodiazepine derivative. It has potent anxiolytic, amnestic, hypnotic, anticonvulsant, skeletal muscle relaxant, and sedative properties.
Nubain\textsuperscript{15} IV and another 100 mcg of Fentanyl IV. At 4:14 p.m., the PTCA balloon was removed from the right coronary artery.

20. Dr. Buchbinder testified that he became very frightened as a result of Richard M.’s agitation around 4:14 p.m. He had never seen any patient act like that before, and he thought there might be catastrophic consequences as a result of Richard M.’s level of agitation, including death. In the 45 minutes or so that followed, Dr. Buchbinder thought it possible that Richard M. might be in the midst of a narcotic withdrawal, but he also considered it possible that Richard M. might be having an adverse reaction to the narcotics or a severe paradoxical reaction to Versed. He did not know. He continued with the procedure because he had dilated the blood vessels of the heart and they would be compromised if a stent was not put in place.

Richard M. tried to sit up on the table several times, which put pressure on the abdomen and jeopardized the placement of the femoral sheath. The Cath Lab staff gathered around the procedure table and tried to hold Richard M. down. Richard M. attempted to bend his knees. Dr. Buchbinder thought about calling for help, but he did not do so; throughout this period of agitation, Dr. Buchbinder attempted to communicate with Richard M. and to physically restrain him, all the while seeking to complete the interventional procedure. The catheter was removed at 4:24 p.m., so that only the femoral sheath remained in the patient.

21. In the 45 minutes or so that followed the intervention into the right coronary artery – from approximately 4:15 p.m. until 5:00 p.m. – several individuals in the Cath Lab observed Dr. Buchbinder engage in some of the conduct that gives rise to the accusation. There was disagreement about the details, in part due to the differing physical locations of these individuals within the Cath Lab, in part due to the chaos, and in part based upon each witness’s perception of Dr. Buchbinder’s motivation.

Nurse Jolley, who was standing behind Dr. Buchbinder, heard Nurse Harte ask Dr. Buchbinder if he wanted her to contact anesthesia, to which he replied, “No, we are almost done with the procedure.” Nurse Jolley did not see Dr. Buchbinder strike Richard M., but she heard him telling Richard M. “rather loudly” to be quiet and to not move.

Yeager, a cardiovascular technician, observed Dr. Buchbinder forcefully strike Richard M.’s forehead with his left elbow when the patient tried to sit up, he heard Dr. Buchbinder yell at the patient in a loud and aggressive manner, and he saw Dr. Buchbinder repeatedly strike the patient’s abdominal area with his left forearm in a chopping fashion. Dr. Buchbinder appeared to be angry. Yeager recalled that when Dr. Buchbinder was asked if anesthesia should be called, he responded by saying, “We don’t need that.”

Jill Harte (Nurse Harte), a registered nurse, was not part of the team. She entered the Cath Lab at Yeager’s request when the procedure was about 75 percent completed. Richard M. was anxious, agitated and uncomfortable, flailing about on the procedure table, with Cath

\textsuperscript{15} Notice is taken that Nubain is the trade name for Nalbuphine, a synthetic opioid that is used as an analgesic.
Lab staff trying to hold him down. Nurse Harte had seen agitated patients before in the Cath Lab, but never to that extent. Nurse Harte saw Dr. Buchbinder’s forearm contact Richard M.’s forehead and she watched Dr. Buchbinder push the patient’s head back down to the table. She asked Dr. Buchbinder if he wanted her to call anesthesia on two occasions; on the last occasion, Dr. Buchbinder replied, “No, we are done.”

Reeter, a cardiovascular technician, served as the scrub tech. He saw Dr. Buchbinder strike the patient’s knees with his fist with “substantial force” and yell, “Shut up – stop screaming.” Dr. Buchbinder was quite angry. Reeter saw Dr. Buchbinder push his left elbow into Richard M.’s forehead “pretty hard” when the patient attempted to sit up; the contact involved a strike and involved more than a mere pushing. Dr. Buchbinder pinched the patient’s nail beds, pinched the web between the patient’s index finger and thumb, and bent the patient’s wrist. Reeter believed these techniques were painful and designed to get Richard M.’s attention. Dr. Buchbinder acted in response to Richard M.’s movements. Dr. Buchbinder’s attempts to control the patient were wholly ineffective. Dr. Buchbinder was “definitely out of control.” Reeter had never seen Dr. Buchbinder act like that before.

Jan Kociencki (Nurse Kociencki) was not on the team. She heard yelling from the Cath Lab and a staff member asked her to start an IV for the patient. When Nurse Kociencki entered the Cath Lab, she recalled Richard M. screaming, “I am in pain, I am in pain,” after which Dr. Buchbinder pinched the patient and “in a really nasty way” asked, “Is this the pain you are having?”

Adams, an x-ray technician, helped hold Richard M. down. Dr. Buchbinder became frustrated as the patient’s agitation escalated. Dr. Buchbinder yelled at the patient and told him to remain still. At one point, Dr. Buchbinder threatened the patient by telling him that if he did not stop moving about, Adams would break the patient’s arm. Dr. Buchbinder struck the patient in the legs and below the diaphragm several times, and his elbow struck Richard M.’s forehead. Dr. Buchbinder used “significant force” when he delivered these blows. Dr. Buchbinder bent the patient’s wrist, pinched the web between the patient’s index finger and thumb, and pinched the patient’s fingernail bed. When Dr. Buchbinder was asked if anesthesia should be called, he replied, “No, we are almost done.” The question was asked 20 to 30 minutes before the procedure actually ended.

Julie Logan (Nurse Logan), an employee of the Foundation for Cardiovascular Medicine and one of Dr. Buchbinder’s trusted colleagues, recalled that earlier in the day when Dr. Buchbinder was asked about the pain medications Richard M. was taking, he said he “was not there to cure a pain problem, but to take a look at the heart.” Nurse Logan heard screaming coming from the Cath Lab that afternoon. She entered, saw Richard M. thrashing about, and observed that Dr. Buchbinder was “quite calm” under the circumstances, asking the patient in a loud manner, “What’s going on?” Dr. Buchbinder’s left elbow contacted Richard M.’s forehead when the patient tried to sit up – it happened very quickly. She saw Dr. Buchbinder try to push the patient’s legs down. When Nurse Harte asked if anesthesia should be called, Dr. Buchbinder said, “No, we are almost done.” After the intervention was completed, Dr. Buchbinder said, “Let’s put an angioseal in,” which was unusual because Dr.
Buchbinder usually did not use an angioseal device to close a femoral puncture. Nurse Logan testified she saw nothing wrong in Dr. Buchbinder’s treatment of the patient.

Nurse Wilkerson entered the Cath Lab around 4:30 p.m. The patient was very combative. Dr. Buchbinder asked Nurse Wilkerson to go to the pharmacy and get 10 mg of Haldol. Nurse Wilkerson left, went to the pharmacy, obtained Haldol, and returned. The event log indicated that an effort to administer 10 mg of Haldol IV was made at 4:40 p.m. The Haldol had no effect, so it was thought possible that the patient’s IV might have become disengaged in the struggle. Nurse Wilkerson returned to the pharmacy, obtained more Haldol, returned to the Cath Lab, and 10 mg of Haldol was administered IM at 4:53 p.m. Richard M. remained out of control.

Joyce Velay (Nurse Velay) was not on the team, but Dr. Buchbinder asked her to come in to help other staff members hold Richard M. down. She entered the Cath Lab and held Richard M.’s legs down, sometimes lying across them. Richard M. kept saying, “I’m in pain,” after which Dr. Buchbinder asked, “What kind of pain are you in? Tell me.” Nurse Velay thought Dr. Buchbinder might have been nervous with the patient, but she was in no position to see if Dr. Buchbinder actually struck the patient.

22. Dr. Buchbinder agreed that the patient was calm and cooperative during the diagnostic phase of the procedure.

Dr. Buchbinder claimed that when the patient became agitated during the interventional procedure, he used his left elbow and forearm to return Richard M. to a flat position on the procedure table, that he forcefully pushed Richard M.’s legs down several times, and that put his left forearm on Richard M.’s abdominal area in fairly rapid sequence to control the patient. Dr. Buchbinder testified that he was “captain of the ship” and it was apparent that the amount of force the Cath Lab staff members were using was insufficient to control the patient, requiring him to use more force to gain control and complete the procedure. He testified that he was frustrated, anxious, nervous and frightened, and that he was also upset with the patient. He conceded that, in retrospect, the amount of force he used may have been related to his emotional state, but claimed his motivation throughout was to protect the patient from injuring himself and to successfully complete the procedure.

Dr. Buchbinder admitted that he made a comment during this phase of the procedure about it being possible that a Cath Lab staff member might break Richard M.’s arm if Richard M. continued to struggle. He recalled this was a warning rather than a threat.

23. There was conflict concerning Dr. Buchbinder’s precise activities during the interventional procedure. What was not disputed was the unexpected onset of Richard M.’s agitation and combative state, the grave risks of harm occasioned thereby, and the efforts of those around the procedure table, including Dr. Buchbinder, to maintain Richard M. flat on

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16 Notice is taken that Haldol is the trade name for Haloperidol, an antipsychotic medication. Haldol also has sedative properties and displays a strong action against psychomotor agitation due to a specific action in the limbic system. However, in some cases, Haldol may worsen psychomotor agitation via its potent Dopamine receptor antagonism.
the table so the procedure could be completed. There was no dispute that Dr. Buchbinder became upset, frustrated and increasingly angry, that he yelled at the patient, and that he attempted to forcefully restrain the patient.

In this highly charged, confusing milieu, the clear and convincing evidence did not establish that the physical force Dr. Buchbinder used in an effort to control Richard M. was excessive or that his techniques were inappropriate, although it was certainly reasonable for some who were there to draw that conclusion given Dr. Buchbinder’s comments and frenzied emotional state.

24. During the procedure, Dr. Buchbinder made a comment to the effect, “If you don’t stop moving around, that man over there [Adams] will break your arm.”

The defense argued that this comment was a warning to the patient to be mindful that his continued movement might cause injury because of the arm restraint that was then being applied; in the alternative, the defense argued that Dr. Buchbinder’s comment involved an unfortunate and inappropriate statement that was made that was in the heat of the moment.

Complainant argued that the comment in question was a clear-cut threat of physical harm that constituted gross negligence under all the circumstances because that comment could never serve to calm an agitated patient but would, instead, produce additional fear and agitation in the patient.

Dr. Buchbinder’s comment about breaking the patient’s arm was absolutely inappropriate, and it technically constituted gross negligence since it involved the want of even scant care; in extenuation, the comment was made in the heat of the moment and under unique and very trying circumstances. The making of such a comment, by itself and under the circumstances, does not provide grounds to impose administrative discipline.

On the Transfer Gurney:

25. Dr. Buchbinder left the Cath Lab at approximately 5:00 p.m. after deploying the angioseal and went to the control room. He changed out of his scrubs.

Richard M. remained on procedure table in an extremely agitated state. While Dr. Buchbinder was out of the Cath Lab, several Cath Lab staff members transferred Richard M. from the procedure table to a transfer gurney, anticipating Richard M.’s transport to the Intensive Care Unit. Richard M. was physically restrained on the transfer gurney by soft restraints on his arms and legs. Cath Lab staff members remained in the Cath Lab, observing Richard M. to see if further control was required. The fact that some of them left the Cath Lab and that some of them sat nearby to watch Richard M. and that none of them felt it necessary to physically restrain Richard M. after he was placed in soft restraints established that the soft restraints were effective and there was no emergency.

26. Dr. Buchbinder returned to the Cath Lab with Richard M.’s sister-in-law. He was surprised that the Cath Lab staff had moved Richard M. from the procedure table to the
transfer gurney without his order. The sister-in-law attempted to comfort Richard M., but the patient remained agitated. Dr. Buchbinder escorted the sister-in-law back to the family waiting area, and then returned to the Cath Lab.

Immediately after Dr. Buchbinder returned to the Cath Lab, he inspected the angioseal and found it intact. Richard M. was struggling on the transfer gurney, moving his head from side to side and bucking about on the table despite the soft restraints. Richard M.’s movements on the transfer gurney at the time were not troubling to the Cath Lab staff who observed the patient because they did not intervene to hold him down. However, Dr. Buchbinder’s perception of the situation was quite different.

Several Cath Lab members heard Dr. Buchbinder yell, “You are [acting like] an animal” and “If you keep this up I will not take care of you again.” Several Cath Lab members observed Dr. Buchbinder grasp the patient’s nose between his index and long finger, squeeze it firmly and then twist it. After the patient said he was in pain, several Cath Lab members observed Dr. Buchbinder pinch the soft tissue on the patient’s bicep, pinch the web between Richard M.’s index finger and thumb, pinch Richard M.’s nail beds, and ask, “Is this the kind of pain you are having?” At least one Cath Lab staff member heard Richard M. say, “Stop it, that hurts.” Several Cath Lab staff members observed Dr. Buchbinder lightly tap the side of Richard M.’s face with a closed fist. Some staff members observed Dr. Buchbinder bend the patient’s wrist in a forceful and painful manner. Dr. Buchbinder appeared to be very upset.

Despite his testimony to the contrary, Dr. Buchbinder’s actions were not in direct response to patient actions, as had been the case during the interventional procedure. Nurse Harte specifically told Dr. Buchbinder, “Maurice, you can’t do that.” The situation was so alarming that some Cath Lab staff members discussed calling a Code 55 (violent person code) after Dr. Buchbinder left the Cath Lab, an idea that was ultimately rejected because it might cause more harm than good.

Nurse Logan heard many of Dr. Buchbinder’s comments to the patient, but she did not witness him engage in any inappropriate conduct. Nurse Wilkerson also heard Dr. Buchbinder’s comments, but she, too, did not observe any inappropriate conduct while Richard M. was on the transfer gurney. In the same fashion, Nurse Velay did not observe any inappropriate conduct while Richard M. was on the transfer gurney.

Grant Ziegler (Nurse Ziegler), a registered nurse in the Intensive Care Unit, carefully examined Richard M. shortly after Richard M. was admitted to the Intensive Care Unit. Nurse Ziegler did not observe any bruises or other signs of trauma.

Nurse Wilkerson was present the following morning when Dr. Buchbinder visited Richard M. in the ICU. Nurse Wilkerson recalled Dr. Buchbinder telling Richard M. about the incident in the Cath Lab, saying, “I had to use my hands to push your head back down... I even had to put my hands on your nose.” Dr. Buchbinder then told Richard M. that he should discontinue taking the high doses of pain medication he was taking on a daily basis.
27. Dr. Buchbinder testified that after he escorted the sister-in-law back to the waiting area, he reentered the Cath Lab and saw Richard M. flailing about. He said he grabbed the patient’s nose between his fingers to get the patient’s attention and to stop the patient from banging his head side to side on the gurney. Dr. Buchbinder said he told the patient, “Stop it, you are acting like a wild animal.” Dr. Buchbinder testified that he likely was influenced by emotion and that pinching the patient’s nose “was a mistake” even though he intended no harm. Dr. Buchbinder had a “vague recollection” of pinching Richard M. Dr. Buchbinder testified that he was very concerned about Richard M. disrupting the angioseal, and that was why he acted in the manner he did when the patient was on the transfer gurney. Dr. Buchbinder’s emotional state obviously affected his perceptions.

28. There was not a great deal of conflict concerning Dr. Buchbinder’s activities in the Cath Lab following the interventional procedure. Richard M. was moved to a transfer gurney, the angioseal remained intact, several Cath Lab staff members were present in the Cath Lab to provide control, and the patient was not in any immediate medical danger. Dr. Buchbinder was upset. The clear and convincing evidence established that Dr. Buchbinder yelled, “You are [acting like] an animal” and “If you keep this up I will not take care of you again.” Dr. Buchbinder grasped the patient’s nose and twisted it, pinched the soft tissue on the patient’s bicep, pinched the web between the patient’s index finger and thumb and nail beds, and asked the patient, “Is this the kind of pain you are having?” He lightly tapped the side of the patient’s face three times with a closed fist.17

While the experts disagreed on what Dr. Buchbinder may have intended and had differing interpretations concerning Dr. Buchbinder’s actions and comments, the experts agreed on this: the intentional infliction of pain upon a patient without a medical indication constitutes gross negligence.

The clear and convincing evidence established that the nature of Dr. Buchbinder’s conduct and the words he uttered to Richard M. while he was on the transfer gurney involved the want of even scant care and constituted one or several acts of gross negligence. Unlike the questionable conduct during the interventional procedure, there was absolutely no justification for the intentionally painful conduct Dr. Buchbinder inflicted when Richard M. was on the transfer gurney, nor was there any reason for Dr. Buchbinder to tell this already agitated patient that he would no longer care for him. The misconduct was the direct result of Dr. Buchbinder being angry and out of control.

The Propriety of the Interventional Procedure

29. Dr. Buchbinder testified that in the course of the diagnostic procedure, he determined that there was a 70 to 80 percent blockage of the circumflex and that there was a 70 to 80 percent blockage of the right coronary artery. Dr. Buchbinder testified that he believed Richard M.’s symptoms were consistent with an acute coronary syndrome and that

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17 The evidence of this wrongdoing is no less clear or convincing because three Cath Lab staff members, two of whom remain Dr. Buchbinder’s trusted colleagues, failed to see what the others clearly observed. The lack of petechia, significant bruising or other evidence of trauma did not establish that wrongdoing did not occur.
immediate intervention with stenting was appropriate. Dr. Buchbinder believed that the risks in proceeding with the intervention were no greater than stopping the procedure and having the patient undergo a pharmacologic stress test. Dr. Buchbinder testified that the Cath Lab was not equipped to enable him to conduct a flow wire evaluation.

30. Bruce VanNatta, M.D. (Dr. VanNatta)\textsuperscript{18}, complainant’s standard of care expert, is a board certified interventional cardiologist. Dr. VanNatta reviewed the patient’s angiograms and believed there was a 40 percent blockage of the circumflex and a 50 to 60 percent blockage of the right coronary artery. Dr. VanNatta believed that because the patient had no chest pain at the time of catheterization, because there were no EKG changes, and because there were negative troponins, the standard of care required a pharmacologic stress test or a flow wire evaluation before proceeding with an intervention. Dr. VanNatta testified that the possibility of a stent being rejected and the need for the patient to be on blood thinners after the intervention made a pre-intervention assessment appropriate.

Dr. VanNatta believed that Dr. Buchbinder’s failure to conduct further investigation before the stenting was a simple departure from the standard of care. Dr. VanNatta was not provided with information concerning Richard M.’s cardiac testing in the 1990s and the false negatives related to that testing.

31. Richard Friedman, M.D. (Dr. Friedman)\textsuperscript{19}, respondent’s standard of care expert, is also a board certified interventional cardiologist. Dr. Friedman reviewed the patient’s angiograms, but unlike Dr. VanNatta, he concluded that there was sufficient occlusion depicted in the angiograms to justify the interventional procedure. Dr. Friedman testified that an angiogram is the “gold standard” in determining the anatomy of the heart and the presence of coronary artery disease, and that the results of any supplemental testing would not have been helpful in reaching a decision to proceed with intervention. He testified that the angiograms did not always depict the extent of narrowing, and that was true in this matter based upon the angle from which the image was obtained. Dr. Friedman, like Dr. Buchbinder, believed that Richard M.’s past history demonstrated the presence of significant coronary artery disease despite the presence of abnormal EKG testing and the absence of

\textsuperscript{18} Dr. VanNatta obtained a medical degree from the Indiana University School of Medicine in 1980, completed a residency in Pathology at the UC Irvine School of Medicine in 1981, completed a residency in Internal Medicine at Pacific Medical Center in San Francisco in 1984, and completed a Fellowship in Cardiology at UC Irvine School of Medicine in 1987. He is board certified in Internal Medicine, Cardiology, and Interventional Cardiology. He is the Director of the Cardiology Fellowship Program at Long Beach Memorial Center and is the Director of the Cath Lab at St. Mary’s Medical Center of Long Beach. He has published numerous scholarly articles and has been a primary investigator, co-investigator, and sub-investigator in many medical trials. Dr. VanNatta does not know Dr. Buchbinder, although he knows of him.

\textsuperscript{19} Dr. Friedman obtained a medical degree from the University of Minnesota Medical School in 1975, completed an internship at Scripps Mercy Hospital in 1976, completed a residency in Medicine at Scripps Mercy Hospital in 1978, and completed a Fellowship in Cardiology at Scripps Mercy Hospital in 1980. He is board certified in Internal Medicine, Cardiology, Interventional Cardiology, and Critical Care Medicine. He was the Chief of Cardiology at Scripps Mercy Hospital from 1994-1996 and the Assistant Director of the Scripps Mercy Cath Lab from 1978 to the present. He has published numerous scholarly articles and has been an investigator in many medical trials. Dr. Friedman does not associate personally or professionally with Dr. Buchbinder, although he knows of him.
positive triponins. Dr. Friedman believed this patient's somewhat unique history precluded any need for additional testing.\textsuperscript{20}

32. The credible expert testimony was in conflict. The clear and convincing evidence did not establish that Dr. Buchbinder's decision to perform angioplasty without first obtaining a further assessment through the administration of a pharmacologic stress test or a flow wire evaluation involved simple negligence, although other reasonable practitioners might have administered those tests.

The Failure to Obtain an Anesthesia Consult

33. Dr. Buchbinder was asked by a nurse before the procedure began if he wanted to consult an anesthesiologist due to the patient's pain medication usage and the possible impact that might have upon conscious sedation. Dr. Buchbinder decided that a consult was not necessary. He reached this conclusion after his nurse practitioner determined what medications Richard M. was taking, after Dr. Buchbinder maintained Richard M. on the same medication regimen, after the nurse practitioner called Richard M.'s pain management physician and inquired about the propriety of the proposed procedure, and after he was told that there would be no problem in proceeding. Dr. Buchbinder had performed cardiac catheterizations for patients who were narcotic dependent before without difficulty.

Dr. Buchbinder testified that he did not call anesthesia immediately after Richard M. became agitated because his past experience at Scripps with the Department of Anesthesia led him to believe that an anesthesiologist would not respond immediately and that the situation he was faced was sufficiently under control that he could complete the procedure without an anesthesiologist. Other credible witnesses confirmed that there was a delayed response by the Department of Anesthesia following a call for help from the Cath Lab. Dr. Buchbinder further testified that if anyone should have been called during the procedure, it should have someone from the Emergency Department because the Emergency Department promptly responded to calls for help and had the ability to intubate the patient if that were necessary. Finally, Dr. Buchbinder contacted anesthesia after the procedure was completed and while Richard M. remained agitated.

Although Dr. Buchbinder believed, in retrospect and after much reflection, that he should have called for help, he did not believe that his decision to continue with the procedure without calling for assistance from anesthesia constituted simple negligence.

34. Dr. VanNatta had never seen a patient taking as much daily pain medication as Richard M. Dr. VanNatta testified that Richard M.'s high use and dependence upon pain

\textsuperscript{20} Dr. Friedman testified that the extent of the lesions Dr. Buchbinder identified was ultimately confirmed on intervention by observing the extent to which the balloons inflated, and that there was an 80 percent narrowing of the circumflex and a 90 percent narrowing of the right coronary artery. This information was irrelevant since it did not and could not play a role of a reasonable and prudent interventional cardiologist's decision making process before the intervention.
medications required Dr. Buchbinder to consult with anesthesiologist. Dr. VanNatta did not believe that the failure to have an anesthesiologist present when the procedure began violated any standard of care, but he believed that Dr. Buchbinder should have given notice to the Department of Anesthesia that the services of an anesthesiologist might be needed. Dr. VanNatta did not mention whether this alleged departure from the standard of care involved simple negligence or gross negligence.

Dr. VanNatta testified that when Richard M. became agitated and combative, the standard of care required that efforts be made to control Richard M. by giving verbal commands to the patient, providing physical restraint by staff members, providing soft restraints, providing restraint through medication, and finally by contacting the Department of Anesthesia for assistance. Dr. VanNatta believed the failure to contact the Department of Anesthesia during the procedure after the patient was agitated and combative constituted gross negligence.

35. Dr. Friedman had treated patients with a narcotic usage history similar to Richard M. He believed that the standard of care required an interventional cardiologist to maintain the patient's medical regimen and that it was not necessary to consult with an anesthesiologist before the procedure began. Dr. Friedman testified that once Richard M. became agitated, Dr. Buchbinder proceeded in a reasonable fashion.

Dr. Friedman testified that there was no precise standard of care for the situation Dr. Buchbinder faced because it was so unique, and that the broad standard of care upon an interventional cardiologist at that point was to do all that was necessary to complete the procedure as quickly as possible while providing as much patient safety as possible. Dr. Friedman described it as "a no-win situation – you do the best you can." Dr. Friedman testified that intubating Richard M. was contraindicated because the patient had COPD and might become ventilator dependent.

36. Dr. Buchbinder's staff contacted Richard M.'s pain management physician before the procedure began and was told that conscious sedation was appropriate. There was no need to obtain an additional anesthesia consult, although doing so would not have caused any problems. There was no need under the circumstances to notify the Department of Anesthesia that its services might be required, since Richard M.'s agitation and combativeness during the catheterization were unique and not reasonably foreseeable.

During the course of the procedure, a need for help to control the patient arose and that need was met, in part, when Dr. Buchbinder asked members of the Cath Lab who were not assigned to Richard M.'s case to come in and help him and other Cath Lab staff members physically restrain Richard M. Dr. Buchbinder also sought to control Richard M. through the administration of various medications during the procedure. Even though these efforts did not prove successful, they were reasonable at the time and nothing more was required by the standard of care.

Given the difficulty Dr. Buchbinder had previously experienced getting a member of the Department of Anesthesia to respond to a call for assistance, Dr. Buchbinder cannot be
found grossly negligent for failing to call for an anesthesia consult (as alleged), even though in retrospect and with the benefit of hindsight it may have been a good idea if he had called the Emergency Department for help.

The credible expert testimony was in conflict. The clear and convincing evidence did not establish that Dr. Buchbinder’s failure to consult the Department of Anesthesia before the procedure began involved negligence, or that his decision to complete the procedure without contacting the Department of Anesthesia involved a departure from the standard of care under the circumstances, even though other reasonable interventional cardiologists might have called the Department of Anesthesia for help.

**The Administration of Narcan:**

37. When the catheterization procedure began, Richard M. was given Fentanyl, a synthetic pain reliever approximately 100 times more potent than morphine, Versed, an ultra short-acting benzodiazepine derivative used as a sedative, and Benadryl, a medication with antiemetic, sedative and hypnotic properties. As the procedure continued, escalating doses of Fentanyl and Versed were administered. Nubain, a synthetic opioid agonist-antagonist analgesic, was administered IV at 4:12 p.m. Around 4:21 p.m., Phenergan was administered IV. Escalating doses of Versed, Fentanyl and Phenergan continued. At 4:40 p.m., 10 mg of Haldol was administered IV, but there was no response to that medication and the medical staff was uncertain if the IV was working. Another 10 mg of Haldol was administered by intramuscular injection at 4:53 p.m. and again at 5:21 p.m. without effect. By that point, 550 mcg of Fentanyl, 25 mg of Haldol, and 5 mg of Versed had been administered to Richard M.

The Medication Event Log indicated that two mg Narcan was administered IV at 5:21 p.m., when Richard M. was on the transfer gurney and that 0.100 mg of Romazicon was administered IV at 5:22 p.m. These reversal agents were administered after the interventional procedure concluded.

Dr. Buchbinder testified that high doses of sedatives and narcotics were administered in an effort to keep the patient comfortable and to control his agitation, but those medications

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21 Notice is taken that Phenergan is an antiemetic medication with strong sedative effects. The Medication Events Log indicated that Phenergan was given for sedation in this matter.

22 Notice is taken that Haldol is the tradename for Haloperidol, an antipsychotic medication used to treat acute psychotic states and delirium.

23 Narcan is the tradename for Naloxone, a drug used to counter the effects of opioid overdose, for example a heroin or morphine overdose. Naloxone is specifically used to counteract life-threatening depression of the central nervous system and respiratory system.

24 Romazicon is the tradename for Flumazenil, a benzodiazepine antagonist used as an antidote in the treatment of benzodiazepine overdoses. The onset of action is rapid and usually effects are seen within one to two minutes. The peak effect is seen at six to ten minutes. Many benzodiazepines have longer half-lives than Flumazenil. Therefore, repeat doses of Flumazenil may be required to prevent recurrent symptoms of overdosage once the initial dose of Flumazenil wears off.
failed. Contrary to the allegations in paragraph 13 of the accusation, Dr. Buchbinder had some experience in treating patients in opiate withdrawal during a procedure, although that did not involve more than 10 or 15 patients and no patient who was as opioid dependent as Richard M. Based upon his training and experience, and given the amount of narcotics he had administered and Richard M.’s continuing agitation, Dr. Buchbinder believed that it might be possible that Richard M. was having an overdose reaction to the narcotics or a paradoxical response to the Versed. It was on this basis that he discontinued the narcotics and sedatives, and authorized the administration of Narcan and other reversal medications.

38. Dr. VanNatta testified that Richard M. was taking more prescription pain medications daily than any patient he had ever seen. Dr. VanNatta testified that a patient in the midst of opiate withdrawal is very sensitive to pain, is somewhat in touch with reality, is not truly delirious, but is unable control his behavior. He believed that Richard M. was in the midst of a narcotic withdrawal and that was why the patient was agitated. Dr. VanNatta had the benefit of knowing from the care that was provided to Richard M. by Dr. Lars Newsome (Dr. Newsome) after the procedure that Richard M. had likely experienced an opiate withdrawal and that was the cause of his pain and agitation.

Dr. VanNatta believed that Dr. Buchbinder should have had a good working knowledge of sedation and pain medication as a result of performing more than 20,000 interventional procedures, and that Dr. Buchbinder should have recognized that the patient was having opioid withdrawal. Dr. VanNatta testified that Narcan should never be given to a patient in opioid withdrawal, and that doing so has the effect of worsening the problems that are caused by such withdrawal. He believed that the administration of Narcan was a simple departure from the standard of care.

39. Dr. Friedman is also board certified in critical care. Dr. Friedman’s review of the records, including the angiograms, caused him to conclude that Richard M.’s extreme agitation had a rapid onset, which was inconsistent with the gradual onset associated with an opiate withdrawal. He believed that Richard M. had an idiosyncratic reaction to a narcotic medication and a paradoxical reaction to Versed. Dr. Friedman testified that he understood Dr. Buchbinder’s reasoning process in ordering Narcan, that it was factually based, that it was sound, and that the decision to administer Narcan was within the standard of care. Dr. Friedman conceded that his opinion regarding the possibility of an idiosyncratic reaction to opioids was contrary Dr. Newsome’s conclusion.

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25 Paragraph 12 of the accusation alleged: “During the procedure, Respondent caused a narcotic reversal agent (Narcan) to be administered to patient R.M., which administration was contraindicated and worsened the situation.” The accusation did not allege any misconduct with regard to the administration of any other medication.

26 Dr. Newsome is with the Department of Anesthesiology at Scripps who engages in a pain management practice. Dr. Newsome saw Richard M. in the ICU on August 24, 2007. Richard M. was agitated, combative, and complained of pain. Dr. Newsome determined there had been a significant reduction in Richard M.’s usual opioid medications upon hospitalization and administered Dilaudid IV for approximately one half hour, after which Richard M. showed significant improvement.
40. Before the procedure began, Dr. Buchbinder believed that Richard M. had been continued on his daily pain medications; he had no reason to believe the contrary although that was, in fact, the case. During the procedure, Dr. Buchbinder administered enormous amounts of narcotics and sedatives to keep Richard M. calm, all to no avail. Dr. Buchbinder had a factual basis to believe it possible that Richard M. was experiencing a narcotic overdose and a paradoxical reaction to Versed, and he responded to those reasonable beliefs by administering Narcan and Romazicon. His response fell within the standard of care. He cannot be faulted for not knowing what became known only after Richard M. was admitted to the ICU (i.e., that Richard M. had not been provided with his usual doses of pain medication before the procedure).

Factual Conclusions regarding Simple Negligence and Gross Negligence

41. The clear and convincing evidence established the following matters: Dr. Buchbinder’s decision to proceed with cardiac intervention without further testing did not violate the standard of care; Dr. Buchbinder’s failure to request an anesthesia consult before the procedure began did not violate the standard of care; Dr. Buchbinder’s failure to call for anesthesia during the procedure did not violate the standard of care; Dr. Buchbinder’s decision to administer Narcan did not violate the standard of care; Dr. Buchbinder did not engage in any physical acts during the interventional procedure that constituted gross negligence or repeated negligent acts; Dr. Buchbinder’s comment in which he mentioned the breaking of Richard M.’s arm was wholly inappropriate, but extenuating circumstances excused this impulsive comment from being grounds to impose discipline; and Dr. Buchbinder engaged in several acts of gross negligence or a single act of gross negligence when Richard M. was on the transfer gurney in that he yelled at the patient and said, “You are [acting like] an animal” and “If you keep this up I will not take care of you again,” he grasped and twisted the patient’s nose, he pinched the patient to cause pain, he lightly tapped the patient’s face with a closed fist, and he bent the patient’s wrist in a painful manner, all without any medical justification and as a product of his anger. While there were several separate acts, the entire incident is considered to be a global act of gross negligence for purposes of this proposed decision. Whether the incident is characterized as several acts of gross negligence or a single act of gross negligence makes no difference in the outcome of this proceeding or in the measure of discipline that should be imposed.

Dr. Buchbinder’s Anger Management Treatment

42. Respondent, through counsel, suggested that complainant sought to impose discipline upon Dr. Buchbinder in large measure for his history of troubled interpersonal relationships at Scripps and not solely as a result of any alleged misconduct involving his interaction with Richard M.

Complainant argued that Dr. Buchbinder’s aggressive interaction with Richard M. and his assertions about his rehabilitation from his anger management problems could not be viewed in isolation, but needed to be measured by what had happened in the past, and that Dr. Buchbinder’s lengthy history of misconduct arising out of his anger issues and his refusal to come to grips with his problem was the best predictor of his future behavior.
43. Dr. Buchbinder's past anger management problems, his previous efforts to address those problems, and his success in the treatment of those problems were relevant to Dr. Buchbinder’s willingness and capacity to resolve any anger management problems he has at present and which may pose a risk of harm to the public in his capacity as a licensed physician. Dr. Buchbinder’s past anger management history, his treatment, and his success in dealing with the problem is the subject of Finding 10.

44. Dr. Nemiroff received his medical degree from State University of New York, Upstate Medical Center, Syracuse in 1962. He completed a residency in Psychiatry at Yale University in 1966. He underwent psychoanalytic training at Western New England Institute for Psychoanalysis in New Haven, Connecticut in 1971. He was certified in Psychoanalysis by the San Diego Psychoanalytic Institute in 1973. He served as a Clinical Professor of Psychology at Yale University and at the University of California, San Diego, School of Medicine. He was in private psychiatric practice from 1967 through 2007 in New Haven and San Diego. He retired from practice in 2008.

Dr. Nemiroff evaluated Dr. Buchbinder in March 2003 and treated Dr. Buchbinder in nine sessions extending through July 2003. The 2003 treatment focused on Dr. Buchbinder’s perfectionist attitude and the anxiety and anger issues related thereto. Dr. Nemiroff felt there was “quite a change” after these sessions and he so advised the MEC.

Dr. Buchbinder consulted Dr. Nemiroff on October 9, 2007, to formulate a treatment plan following the Cath Lab incident. Dr. Nemiroff believed that Dr. Buchbinder, whose privileges had been suspended, was highly motivated to follow recommendations that he seek therapy at that time and that Dr. Buchbinder wanted to understand what contributed “to these misperceptions and misunderstandings about the intensity of his emotions and his high medical standards.” Dr. Buchbinder agreed to a therapy plan that included psychotherapy, psychological testing and anger management counseling.

Dr. Buchbinder’s initial attitude towards the MEC investigation was one of disbelief, according to Dr. Nemiroff. He was upset and mystified by the incident, asking, “Why are people upset with me? I saved the patient’s life.” At first, Dr. Buchbinder believed his actions were heroic, but over time, according to Dr. Nemiroff, he realized how his conduct was inappropriate, aggressive, and ineffective. Dr. Buchbinder felt remorse, and he was very concerned about how the patient, his colleagues, and the community viewed him.

Dr. Nemiroff observed that after Dr. Buchbinder received staff privileges at Alvarado Hospital and was closely monitored, there were absolutely no reports of any interpersonal or anger related problems. Dr. Buchbinder’s performance exceeded all expectations.

Dr. Buchbinder treated with Dr. Nemiroff through August 14, 2008. Dr. Nemiroff retired from practice shortly thereafter.
Dr. Nemiroff testified that the Cath Lab incident was a “very unusual,” that the negative consequences arising out of that incident resulted in Dr. Buchbinder hitting bottom, and that after that Dr. Buchbinder “finally got it.”

Dr. Nemiroff believed that Dr. Buchbinder had learned a very difficult lesson and no longer posed any harm to the public.

45. Alan Sugarman, Ph.D. (Dr. Sugarman) received a Ph.D. in Psychology from the University of Tennessee, Knoxville in 1974. He holds certification in Adult Psychoanalysis and certification in Child and Adolescent Psychoanalysis from the San Diego Psychoanalytic Institute. He has practiced as a clinical psychologist in San Diego since 1981. Before that, he served on the faculty at the Yale Psychiatric Institute, Yale University, from 1976 thorough 1981. After coming to San Diego, Dr. Sugarman served on the faculty at the San Diego Psychoanalytic Society and Institute and he serves as a Clinical Professor of Psychiatry at the University of California, San Diego, School of Medicine. Dr. Sugarman holds numerous honors and awards. He has engaged in extensive scholarly activities and has published many journal articles.

On December 15, 2007, Dr. Sugarman administered a battery of psychological tests that included the Wechsler Adult Intelligence Scale-Revised (WAIS-R), the Babcock Story Recall Test, the Rorschach Ink Blot Test, and the Thematic Apperception Test (TAT). This battery of tests was appropriate to assess Dr. Buchbinder’s psychological functioning.

The test results revealed an absence of serious psychopathology. There was no evidence of an Axis I or an Axis II problem. Anger was not a prominent feature of Dr. Buchbinder’s makeup and he was capable of regulating his affect. There was no evidence of any thought disorder. There were no antisocial or psychopathic personality features, although there was some evidence of a self-enhancing attitude.

Dr. Sugarman did not discuss the facts related to the Cath Lab incident with Dr. Buchbinder since his assignment involved testing only.

46. David Wexler, Ph.D. (Dr. Wexler) received a Ph.D. in Clinical Psychology from the California School of Professional Psychology in 1982. He completed a postdoctoral fellowship at Mercy Hospital in 1983. He has been in private practice since then. Dr. Wexler has served on the faculty at the California School of Professional Psychology and at United States International University. He is on the staffs at Scripps Mercy Hospital and Sharp Mesa Vista Hospital. Dr. Wexler has written several books. He specializes in anger management and men’s issues.

Dr. Wexler first met with Dr. Buchbinder on November 20, 2007. Dr. Wexler interviewed Dr. Buchbinder and administered the Millon Clinical Multiaxial Inventory-III and the Anger Styles Quiz. Dr. Buchbinder reported that his conduct with Richard M. involved chopping motions, pinning the patient down, grabbing the patient’s nose, and pinching the patient to gain control after the patient became agitated. Psychological testing showed a tendency to depression, avoidance, the presence of some passive-aggressive
behaviors, and the waxing and waning of these features based upon stress. Dr. Buchbinder was motivated during testing and he was cooperative and open to change throughout the six sessions extending through January 15, 2008.

Dr. Wexler described Dr. Buchbinder’s anger pattern as involving moral anger, which related to his belief that he was in the right, and habitual hostility, which related to irritability and a tendency to become angry under stresses that would not bother others.

Dr. Wexler described how Dr. Buchbinder’s perception of his conduct of Richard M.’s care evolved over the course of treatment. Dr. Buchbinder was initially defensive, believing that he had done nothing wrong and that he was being unfairly accused. Over time, Dr. Buchbinder came to believe that he had overreacted, even though he maintained that he always intended to provide excellent patient care. He expressed remorse, regretting any physical pain he may have caused the patient. He spent a lot of time discussing the future, how he intended to interact with staff in a more positive fashion, and how this would ultimately benefit his patients.

Dr. Wexler believed that Dr. Buchbinder had a history of anger management problems, that his maladaptive behavior was motivated by his perfectionism and a failure to recognize the concerns of others, and that he was motivated to change his behavior.

Dr. Wexler believed Dr. Buchbinder made great progress in counseling and that he did not present any risk of harm to the public.

47. Giovanna Zerbi, Psy.D. (Dr. Zerbi) received a doctorate in Clinical Psychology from the Professional School of Psychological Studies in San Diego in 1993. She has been in private practice since then, specializing in impulse control and dialectic behavior therapy. Dr. Zerbi is affiliated with UCSD’s Physician Assessment and Clinical Education (PACE) Program and she has been its Anger Management Course Director since 2005.

Between January 2008 and February 2008, Dr. Zerbi and Dr. Buchbinder met four hours a weekend over the course of six weeks in a therapy program specifically tailored for Dr. Buchbinder. In addition to these sessions, Dr. Buchbinder was assigned considerable homework, all of which he completed. Dr. Buchbinder presented himself as willing to learn new strategies to control his anger, telling Dr. Zerbi that when Richard M. became agitated, he responded in an unskillful manner even though he was trying to save the patient’s life. Dr. Buchbinder admitted he was initially baffled by the charges levied against him, but that he finally came to understand his role in the incident.

The therapy had three phases: Phase I was a skill teaching phase, requiring Dr. Buchbinder to consider how individuals react to emotions and how there are various points of intervention that exist along the way when reacting to emotions; Phase II was the reflective phase, in which Dr. Buchbinder had to consider how the practice of medicine impacted his life and how his self-perception affected his behavior with others; Phase III involved an action plan, in which Dr. Buchbinder summarized what he had learned and made
a commitment to change. Dr. Zerbi found Dr. Buchbinder open to therapy, and she believed he made “major strides.” He came to realize that “I behaved like a jerk.”

Dr. Zerbi met with Dr. Buchbinder again in January 2009. During that meeting, she observed “significant changes in his stance to the world.” Dr. Buchbinder was far more aware of how his behavior had affected his career, relationships, and sense of self. He was anxious about the pending disciplinary hearing, and he expressed regret and concern for his situation. He was tearful. The majority of the session involved Dr. Buchbinder reflecting on how his interaction with Alvarado Hospital Cath Lab staff members had changed from the situation existing at Scripps, how his life had changed for the better, and how his life could have been different had he made effective changes before.

Dr. Zerbi believed that Dr. Buchbinder did not present a risk of harm to the public.

48. The uncontradicted testimony of Dr. Nemiroff, Dr. Sugarman and Dr. Zerbi was supplemented and explained by the comprehensive narrative report of Steven A. Ornish, M.D. (Dr. Ornish), who evaluated Dr. Buchbinder on December 16, 2008, at complainant’s request. Dr. Ornish was not called to testify in this matter. Dr. Ornish’s report was received as administrative hearsay over complainant’s objection.27

Dr. Ornish reviewed documents, interviewed Dr. Buchbinder, summarized pertinent records and reports, administered psychological testing (the Minnesota Multiphasic Personality Inventory 2, the Millon Clinical Multiaxial Inventory-III, and the Grossman Personality Facet Scales), administered a mental status examination, developed a DSM-IV diagnosis, and rendered an opinion.

Of interest were Dr. Buchbinder’s comments to Dr. Ornish in the course of the interview, which supplemented Dr. Buchbinder’s testimony in this matter:

27 Complainant commissioned Dr. Ornish’s examination and report, but objected to its admissibility on a variety of grounds. There was no dispute that the report was authored by Dr. Ornish. Nor was there a dispute that the report constituted hearsay. In this regard, Government Code section 11513 provides in part:

“(c) The hearing need not be conducted according to technical rules relating to evidence and witnesses, except as hereinafter provided. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of the evidence over objection in civil actions.

(d) Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions. An objection is timely if made before submission of the case or on reconsideration.”

Dr. Ornish’s report, and the findings and opinions set forth therein, contained the kinds of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. While the report was hearsay, it could be used to supplement and explain other evidence. Indeed, complainant used portions of Dr. Ornish’s report to cross-examine Dr. Buchbinder.
"I am sure I have rubbed people the wrong way over the years and I have done it always in the name of good medical care but, fourteen months later, I have learned that that does not necessarily mean it is always best for the situation at hand, and I have to learn how to manage my needs and my desire in a more appropriate fashion.

For me to sit here and say to you that I have never had an abrasive edge to my personality would be wrong, and I have learned for the last thirteen months to tone that down and work on that.

I had zero intent to settle [the claim brought by Richard M.], because I don’t believe I did anything wrong, but I could not stand the judgment by the newspapers which I knew would be sitting there [in court] and writing me guilty. . . ."

Dr. Ornish observed that Dr. Buchbinder’s version of his interaction with Richard M. varied with some witness statements; it appeared that Dr. Buchbinder minimized some of his more egregious behavior. Dr. Ornish considered the witness accounts to be more reliable than “Dr. Buchbinder’s more self-serving and inconsistent accounts.” This observation supplemented and explained what Dr. Buchbinder perceived in the Cath Lab and how his misperception played a role in his view of his conduct.

Dr. Ornish believed that Dr. Buchbinder’s efforts to manage his anger and frustration before the Cath Lab incident resulted in his gaining some insight, but that the improvement was only transient because the consequences resulting from his unprofessional conduct were inconsequential to him, because the hospital administration failed to set clear boundaries, and because the boundaries that were set were not consistently enforced. This opinion explained why Dr. Buchbinder was unable to remediate his conduct in a more meaningful manner and why his initial treatment with Dr. Nemiroff was not wholly successful.

But, according to Dr. Ornish:

“This all changed after August 24, 2007, when Dr. Buchbinder suffered significant negative consequences for his behavior, including receipt of a notice of impending investigation for medical disciplinary cause or reason, resulting in his abrupt resignation from the medical staff as Scripps Memorial Hospital (his home base); damage to his reputation from adverse publicity from the Union-Tribune article; the settlement of a threatened lawsuit brought by patient Richard M. . . . ; and the threat of sanctions and losing his license by the Medical Board of California should he be deemed to be a danger to the public.”

This statement supplemented and explained how Dr. Buchbinder “hit bottom,” as Dr. Nemiroff described the situation, and why Dr. Buchbinder became genuinely motivated to change, as described by Dr. Nemiroff, Dr. Wexler, and Dr. Zerbi.

Dr. Ornish considered materials provided to him by the Medical Board investigator that were generated by individuals at Alvarado Hospital. These materials described Dr. Buchbinder as being a strong, uncompromising, hard worker, a leader who was both
demanding and sympathetic. Dr. Buchbinder was described as being a pleasure to work with. No patient or staff member complaints had been filed regarding Dr. Buchbinder at Alvarado Hospital. Dr. Ornish believed this evidence provided a "real world" view of how Dr. Buchbinder's had functioned after he resigned from Scripps and was appointed to the Alvarado Hospital staff. Dr. Ornish's opinion in this regard supplemented and explained the testimony of those percipient witnesses who described a change in Dr. Buchbinder's manner after his appointment at Alvarado Hospital.

Dr. Ornish’s report concluded: “Based on the evidence, and my comprehensive forensic psychiatric evaluation, Dr. Buchbinder is not a danger to himself, his patients, or the public, and his ability to practice medicine safely is not impaired by either mental illness, or physical illness affecting competency.”

Dr. Ornish recommended: “I strongly recommend that Dr. Buchbinder return to see Dr. Nemiroff for at least an additional year of psychotherapy to reinforce and consolidate his gains, provide additional emotional support, and further improve his insight.”

**Percipient Witness Testimony Regarding Rehabilitation**

49. Nurse Logan had known and had worked with Dr. Buchbinder since January 2000. Nurse Logan testified about Dr. Buchbinder's “unbelievable rapport” with patients, but she acknowledged his historically strained relationship with hospital staff members at Scripps. She testified that when Dr. Buchbinder worked at Scripps, he had little tolerance for those who made mistakes. Nurse Logan knew about the Scripps investigation, Dr. Buchbinder's suspension and resignation, and she witnessed his reaction to it.

Around the time of the investigation, Dr. Buchbinder and Nurse Logan had a long conversation in which Dr. Buchbinder asked, “Am I really this horrible person?” to which Nurse Logan replied, “You can be an ass and demanding.” Dr. Buchbinder acknowledged that he was a poor leader and that staff did not trust him.

In the first months after his suspension, Dr. Buchbinder spent much of his time in his office brooding. During this period, Dr. Buchbinder asked Nurse Logan, “How could I have fallen this far? How could things have gotten this bad?” When Dr. Buchbinder gained privileges at Alvarado Hospital, “he was like a kid in a candy store.” However, the joy was short-lived because Dr. Buchbinder found that the Alvarado Cath Lab was not well equipped and did not meet the same standards of excellence that he had established at Scripps.

Nurse Logan witnessed a significant transformation in Dr. Buchbinder’s character after he gained privileges at Alvarado Hospital – he was no longer as formal or as abrupt, his tone is different, and he said “Please” and “Thank you” frequently.

Dr. Buchbinder recently was involved in a cardiac catheterization at Alvarado Hospital where the patient became quite agitated. Dr. Buchbinder immediately contacted an Emergency Room physician who administered a paralytic. After the procedure was completed, Dr. Buchbinder told Nurse Logan, “I think I have learned something.”
50. Genaro Fernandez, M.D. (Dr. Fernandez) is the Chief of Staff at Paradise Valley Hospital. He is an interventional cardiologist who has privileges at both Paradise Valley Hospital and Alvarado Hospital.

Dr. Fernandez had professional interactions with Dr. Buchbinder beginning the mid-1990s. Dr. Buchbinder “had exacting methods and on occasion he was not as nice as he could be” at Scripps, sometimes degrading the competency of Cath Lab staff members in front of others. Dr. Fernandez has worked with Dr. Buchbinder in the Cath Lab one to three times a week at Alvarado Hospital since Dr. Buchbinder obtained staff privileges there. The atmosphere in the Cath Lab at Alvarado Hospital is not as tense as it was at Scripps, and Dr. Buchbinder now tells staff “Thank you” and “Good work.”

Dr. Fernandez believed that the incident involving Richard M. resulted in Dr. Buchbinder being required to confront himself and to assess his manner of interacting with others, and that Dr. Buchbinder has become a better person since then as a result insofar as his growing interpersonal skills.

Dr. Buchbinder’s Testimony Regarding Rehabilitation

51. Dr. Buchbinder’s perception of himself, how he interacts with others, and his role in the incident involving Richard M. is evolving.

In August 2007, Dr. Buchbinder told Dr. Launer that “he tried to restrain the patient in order to protect the patient from injuring himself” and that he “forcefully restrained the patient, twisted the patient’s knuckle, and ultimately applied pressure to his nose in lieu of sternal pressure.”

In a letter to Scripps MEC dated September 4, 2007, Dr. Buchbinder wrote in part:

“I am frankly ‘humiliated’ and frustrated by the turn of events that have taken place the past week. I am very disappointed to be found ‘guilty’ of something I honestly do not understand.

I am unsure as to why I am being singled out as the ‘forceful restrainer’ when five (5) other people were doing the same in an attempt to save my patient from disastrous complications secondary to uncontrollable agitation from opiate withdrawal in the midst of a cardiac intervention.

As with others in the room, my sole intent was to restrain the patient in anyway possible in order to avoid amongst other things ‘laceration’ of the femoral artery with the indwelling sheath and subsequent retroperitoneal bleed, hypotension with possible secondary thrombosis of freshly implanted stents and Death . . .
I apologize if my tactics seemed ‘overzealous’ unfortunately fearing the worst I could not help but do everything I could think of to get his attention in order to avoid a certain life threatening complication.

Given the extreme circumstances and our inability to control the patient I took a chance and placed a closure device under extreme duress . . .

Needless to say, I have never faced opiate withdrawal behavior in my 25 year career so I am not sure what could or should have been done differently . . .

I would like to conclude that after all is said and done the patient was discharged in less than 36 hours following this very ‘unusual’ incident without a bruise, scratch or other medical complication following his multi-vessel coronary stent implantation.”

In a letter to Scripps MEC dated November 1, 2007, Dr. Nemiroff advised:

“From his description and the documents of witnesses he brought, it seems clear that following a cardiac procedure he was doing all that was possible to prevent an out-of-control patient from seriously injury or even destroying himself in the midst of a drug withdrawal reaction. There seems to be no intent to harm the patient, indeed; Dr. Buchbinder got the patient through a difficult, life-threatening; time . . .”

But in private, Dr. Buchbinder was asking Nurse Logan if he was “really this horrible person?” He was beginning to examine his role in the Cath Lab incident.

After Dr. Buchbinder began psychiatric treatment in 2007, according to Dr. Nemiroff, he “finally got it.” Dr. Buchbinder became less defensive. He told Dr. Wexler he was sorry for any physical pain he may have caused the patient. Dr. Buchbinder spent a lot of time discussing how he intended to interact with medical staff in a more positive fashion. Dr. Buchbinder admitted to Dr. Zerbi that he had responded in an unskilful manner in dealing with Richard M. even though he was trying to save the patient’s life. While Dr. Buchbinder has admitted no specific wrongdoing in his interaction with Richard M., his self-awareness has evolved to the point where he has admitted to having an anger problem, that he became anxious and frustrated, and that there was a connection between his emotional state and his treatment of Richard M. All this represents progress.

Dr. Buchbinder testified about the devastating feelings that accompanied his loss of staff privileges at Scripps, his embarrassment and his shame for the embarrassment he caused his family and colleagues. He believes that the incident involving Richard M. resulted in his not being appointed to a teaching position at Stanford University, his ineligibility to serve as a principal investigator in the testing of a new medical device he helped develop, and the recent lack of invitations to lecture abroad. While most of the remorse Dr. Buchbinder expressed related to his personal losses, he also expressed some concern for the impact of his actions on patient Richard M. Dr. Buchbinder was, at times, tearful when testifying about the impact of the Cath Lab incident on his life.
Much of Dr. Buchbinder's rehabilitation in the area of anger management occurred while he was at Alvarado Hospital. Dr. Buchbinder's appointment at Alvarado Hospital was specifically conditioned upon Dr. Buchbinder's participation in the Physician's Assistance Committee, which monitors Dr. Buchbinder's activities. Those conditions remain in place. In addition, Dr. Buchbinder has a mentor at Alvarado Hospital, Frank Stella, M.D., with whom he meets on an infrequent basis to discuss how things are going. There have been no reports of any problems concerning Dr. Buchbinder's interactions with others during his tenure at Alvarado Hospital; to the contrary, the reports have been very approving.

Although Dr. Buchbinder denied any malicious intent to cause Richard M. pain, Dr. Buchbinder testified that he has come to believe that his interaction with Richard M. was unacceptable. He now realizes that some of his unacceptable conduct might have been related directly to a fit of anger and his emotional state at the time.

Dr. Buchbinder testified he found much value in the therapy he received, and he plans to continue counseling with Dr. Zerbi for a year.

Witness Credibility

52. No single witness in the Cath Lab, other than Dr. Buchbinder, was in a position to see and hear all the interaction between Dr. Buchbinder and Richard M. While some witnesses had a clear bias for or against Dr. Buchbinder, the simple existence of those biases did not make their testimony unbelievable. No description of any event occurring in the Cath Lab was inherently improbable, but that does not require a finding that what was described actually occurred, particularly when some of the conflicting testimony was based upon presumptions about Dr. Buchbinder's motivation. No percipient witness in the Cath Lab testified untruthfully.

Dr. VanNatta and Dr. Friedman were highly qualified and believable expert witnesses. Each reviewed essentially the same information to form their opinions, but their interpretation of what occurred and what Dr. Buchbinder was thinking led them to several different conclusions. Dr. VanNatta prepared a comprehensive narrative report, which was very helpful to the administrative law judge. Dr. Friedman was not asked to prepare a report, so counsel for complainant did not have the same opportunity for prehearing review that respondent's counsel enjoyed. Dr. Friedman demonstrated a more adversarial approach than Dr. VanNatta, but his style did not require that his opinions and conclusions be disbelieved. Each expert expressed reasonable views concerning the principal quality of care issues (the need for further testing before the interventional procedure, the need to call anesthesia, and the use of Narcan). Dr. Friedman was more familiar with the diagnostic procedures available to practitioners at Scripps than Dr. VanNatta. Dr. Friedman did not rely on information that became known about Richard M.'s narcotic withdrawal in forming his opinions about what Dr. Buchbinder should have done when the patient remained agitated despite the additional administration of narcotics and sedatives. Dr. Friedman's knowledge and experience raised questions about Dr. VanNatta's testimony concerning the standard of care incumbent upon an interventional cardiologist in unique emergent circumstances similar to those involving Richard M., and Dr. VanNatta's opinion appeared to be more about what should be the
standard of care than what the standard of care actually was. On these issues, the clear and convincing evidence did not support a finding of gross negligence or repeated negligent acts.

The experts agreed that a physician’s intentional causing of pain to a patient when that is not required for any medical purpose constituted gross negligence.

Dr. Nemiroff had the longest therapeutic relationship with Dr. Buchbinder. Dr. Nemiroff’s testimony about the changes he perceived in Dr. Buchbinder was credible. Dr. Wexler and Dr. Zerbi provided Dr. Buchbinder with anger management therapy. Each testified about Dr. Buchbinder’s rehabilitation and, like Dr. Nemiroff, each expressed the opinion that Dr. Buchbinder did not pose a risk of harm to the public. Dr. Zerbi’s opinion was entitled to great weight because of her ongoing relationship with the Medical Board through the PACE program, which required her to be extremely careful in her assessment. The testimony of these witnesses was subjected to effective cross-examination that explored the facts upon which their opinions were based. There was no expert testimony that contradicted the testimony of these witnesses.

Dr. Buchbinder’s testimony was the most difficult to assess. He had an enormous stake in the outcome. Through his testimony and the testimony of others, it was apparent that Dr. Buchbinder had a need to be perfect and to be seen by others as being highly competent, and that he sought to justify his misbehavior in the name of patient care. These personality features created blind spots and affected Dr. Buchbinder’s perception of reality. Ultimately, these flaws made it possible for Dr. Buchbinder to engage in egregious conduct in his interaction with Richard M. and to not appreciate that was the case. Bluster, anger and denial had served Dr. Buchbinder well until the MEC suspended his privileges at Scripps and he was embarrassed to his professional and personal core; only then he was forced to take a more meaningful look at himself. The measure of Dr. Buchbinder’s recovery is his ever growing appreciation that he did not handle the Cath Lab situation well and that he is entitled to and should ask for help when things do not go his way. Dr. Buchbinder is an imperfect, flawed individual, but he is not a liar and he has shown that he is capable of meaningful change. He provided the most truthful testimony he could under the circumstances.

The Disciplinary Arguments

53. Complainant argued that Dr. Buchbinder was confronted with a unique and difficult situation, which is not uncommon in the medical profession, which required that Dr. Buchbinder maintain his composure and refrain from acting in anger. Complainant argued that Dr. Buchbinder engaged in repeated negligent acts in the care he provided Richard M., including the decision to proceed with cardiac intervention without further testing, the failure to contact anesthesia before and during the procedure, and the administration of Narcan; more significantly, complainant argued that Dr. Buchbinder’s loss of self-control and his ensuring abuse of Richard M. was so egregious that an outright revocation was the only sanction sufficient to protect the public from this uncaring, unbalanced and dangerous medical practitioner.
In support of the quality of care arguments, complainant argued that Dr. VanNatta’s testimony was more credible than Dr. Friedman’s testimony. On the issue of patient abuse, complainant argued that Dr. Buchbinder was so angry and was so out of control that he intentionally battered Richard M., physically and verbally, and that there was no justification for that. Complainant argued that Dr. Buchbinder still has not taken full responsibility for his misconduct, as demonstrated by his refusal to admit any intentional wrongdoing and his lack of accountability. Complainant argued that Dr. Buchbinder’s treating physicians were unaware of his actual misconduct and their opinions about his rehabilitation and any risk of harm he might pose to the public were thus unsupported.

Complainant argued that if an outright revocation was not proposed, then the administrative law judge should issue a proposed decision that placed Dr. Buchbinder on seven years probation, with a lengthy period of actual suspension, and that in addition to standard terms and conditions of probation, Dr. Buchbinder should be required to take a prescribing course or a course in conscious sedation, be reevaluated by a psychologist or psychiatrist approved by the Medical Board to assure his emotional stability, undergo additional psychotherapy, and have a practice monitor.

Complainant ruled out the propriety of a letter of public reprimand, arguing that a letter of reprimand was appropriate only in the most minor cases and that its issuance was inappropriate where, as here, the physician posed a clear risk of danger to the public.

54. Respondent argued that the Cath Lab incident was unique and involved an enormous risk of patient injury that required Dr. Buchbinder to make instantaneous life and death decisions. Respondent argued that complainant failed to prove the quality of care charges by clear and convincing evidence.

In response to the patient abuse claims, respondent argued that Dr. Buchbinder’s actions were always in response to patient actions, that Dr. Buchbinder’s conduct was always motivated by a desire to protect the patient from himself, and that the absence of trauma after the procedure established that excessive force was never used.

Respondent conceded that he had been difficult to work with in past, but there had never been any claim of patient abuse before the incident involving Richard M., that the incident involving Richard M. captured his attention because of the severe professional and personal consequences he suffered, that he voluntarily sought psychotherapy and treatment, that he engaged in therapy and treatment in good faith, that he made significant progress in therapy and treatment, and that his success at Alvarado Hospital reflected his rehabilitation. Respondent asserted that he was truly remorseful.

Respondent believed that the accusation should be dismissed, but argued that if grounds existed to impose license discipline, then the issuance of a public letter of reprimand without condition was the only reasonable measure of discipline. Respondent observed that the treating psychiatrist and treating clinical psychologists, as well as the board-certified psychiatrist commissioned by complainant, all concluded that Dr. Buchbinder was not a
danger to the public. Since there was no expert evidence to the contrary, imposing probation was unjustified, constituted an abuse of discretion, and would improperly entail punishment.

Disciplinary Guidelines

55. The Medical Board published a Manual of Model Disciplinary Orders and Disciplinary Guidelines (10th Edition). Administrative law judges, defense attorneys, physician-respondents, trial attorneys from the Office of the Attorney General, and the Medical Board’s disciplinary panel members use these guidelines. The guidelines are not binding standards.

Business and Professions Code section 2229 mandates the protection of the public as the highest priority for the Medical Board and the administrative law judges of the Medical Quality Hearing Panel. Business and Professions Code section 2229 specifies that, to the extent not inconsistent with public protection, disciplinary actions should be calculated to aid in the rehabilitation of licensees. The Medical Board adopted the guidelines to implement these mandates. Consistent with these mandates, the guidelines set forth the measure of discipline the Medical Board finds appropriate and necessary for the identified violations.

The Board expects that absent mitigating or other appropriate circumstances (such as early acceptance of responsibility and demonstrated willingness to undertake Board-ordered rehabilitation), administrative law judges hearing disciplinary cases will follow the guidelines. Any proposed decision or settlement that departs from the disciplinary guidelines must identify the departures and the facts supporting the departure.

56. The clear and convincing evidence established that Dr. Buchbinder engaged in a single act of gross negligence, which also constituted general unprofessional conduct, in violation of Business and Professions Code section 2234. For these violations, the guidelines set forth a maximum penalty of outright revocation and a minimum penalty of revocation, stayed, with five years probation. Standard conditions of probation include notice to insurance carriers and hospitals of the discipline imposed, an obligation to submit quarterly declarations, a prohibition against supervising physician assistants, compliance with the directions of the probation unit, submitting to interviews on reasonable request, and payment of probation monitoring costs. Optional conditions of probation that might be warranted by the evidence in this matter include completion of an Ethics course and completion of an additional anger management course.

The Appropriate Measure of Discipline

57. Dr. Buchbinder’s egregious conduct when Richard M. was on the transfer gurney screams for punishment. No licensed physician should be permitted to get away with the kinds of abuse Dr. Buchbinder perpetrated upon Richard M. when the patient was on the transfer gurney. Complainant was absolutely correct – it was unjustified.

Dr. Buchbinder’s evidence of rehabilitation must be measured against his long history of troubled interpersonal relationships in the workplace and his flagrant misconduct in the
Cath Lab. Against this very disturbing backdrop, Dr. Buchbinder offered impressive and uncontradicted evidence of his efforts to deal with his anger issues and established proof of his success in doing so. Dr. Nemiroff, Dr. Sugarman, Dr. Wexler, Dr. Zerbi, Dr. Fernandez, and Nurse Logan established Dr. Buchbinder’s willingness to overcome the personal flaws that led to his misbehavior. Dr. Fernandez and Nurse Logan attested to Dr. Buchbinder’s suitable interaction with staff and his superior performance at Alvarado Hospital. Dr. Buchbinder’s testimony bore the marks of legitimacy as it related to his rehabilitation. This evidence cannot be disregarded.

The quality and quantity of Dr. Buchbinder’s evidence, when weighed against all the wrongdoing occurring in the Cath Lab and all the inferences that should be drawn from it, was sufficient to meet the very heavy burden of establishing that a revocation, suspension, or period of probation is not required to protect the public. Dr. Buchbinder’s acceptance of responsibility and his progress in therapy forms the basis for the recommendation that he be issued a public reprimand.

A public reprimand serves several purposes in this matter. First, it informs Dr. Buchbinder, other practitioners and the public that certain kinds of conduct are absolutely unacceptable. Second, the public reprimand identifies in a public manner the specific wrongdoing Dr. Buchbinder committed and it formally censures him for that. Third, the public reprimand serves as a perpetual reminder to the profession and to the public that Dr. Buchbinder behaved in an unprofessional manner, bringing disrespect to himself and upon the medical community. Fourth, the public reprimand details extenuating circumstances, Dr. Buchbinder’s acceptance of responsibility, his willingness to change, his efforts to remediate himself, and the evidence supporting the conclusion that he is presently fit to practice medicine without the need to impose a measure of discipline that would burden all those involved in the disciplinary process and not better serve to protect the public.

The issuance of a public reprimand in the matter, upon the condition that Dr. Buchbinder attend and complete an board-approved Ethics course within 90 days of the effective date of the decision in this matter and his agreement to participate in a one year board-approved educational program to further assist him in learning more about his personal anger management issues (which may take the form of psychotherapy or counseling) will adequately protect the public.

LEGAL CONCLUSIONS

The Standard of Proof

1. The standard of proof in an administrative action seeking to suspend or revoke a physician’s certificate is “clear and convincing evidence.” (Ettinger v. Board of Medical Quality Assurance (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (Katie V. v. Superior Court (2005) 130 Cal.App.4th 586, 594.)
Purpose of Physician Discipline

2. The purpose of the Medical Practice Act is to assure the high quality of medical practice. (Shea v. Board of Medical Examiners (1978) 81 Cal.App.3d 564, 574.) The state’s power to regulate a profession cannot be used arbitrarily to penalize conduct having no demonstrable bearing upon fitness for its practice. Conduct used as a basis for revocation or suspension of a professional license must demonstrate unfitness to practice that profession. The purpose of an action seeking revocation of a doctor’s certificate is not to punish, but rather to protect the public. While revocation of a certificate certainly works an unavoidable punitive effect, the board can seek to achieve a legitimate punitive purpose only through criminal prosecution. In an administrative proceeding, the inquiry must be limited to the effect of the doctor’s actions upon the quality of his service to his patients. (Watson v. Superior Court (2009) 176 Cal.App.4th 1407, 1416.)

The Imposition of Physician Discipline

3. Business and Professions Code section 2227 currently provides:

“(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel . . . and who is found guilty . . . may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper. . . .”

28 Business and Professions Code section 2233 authorizes the Medical Board to issue a letter of public reprimand without the necessity of filing a formal accusation. Under that statute, “Use of a public reprimand shall be limited to minor violations and shall be issued under guidelines established by regulations of the board.”
4. Business and Professions Code section 2229 provides in part:

“(a) Protection of the public shall be the highest priority for the Division of Medical Quality . . . and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.

(b) In exercising his or her disciplinary authority an administrative law judge . . . shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence . . .”

Unprofessional Conduct

5. Business and Professions Code section 2234 provides in part:

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

(b) Gross negligence.

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

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

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

General Unprofessional Conduct

6. Business and Professions Code section 2234 specifically provides that “unprofessional conduct includes, but is not limited to” certain enumerated conduct. Unprofessional conduct thus exceeds conduct specifically enumerated by statute, but this does not mean that an overly broad connotation should to be given to the term; it must relate
to conduct which indicates an unfitness to practice medicine. Unprofessional conduct is that conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession. (Shea v. Board of Medical Examiners (1978) 81 Cal.App.3d 564, 575.)

Standard of Care, Simple Negligence, Gross Negligence, Repeated Negligent Acts

7. The definition and requirement that there be a standard of care, and the legal definitions of negligence, gross negligence, and repeated negligent acts is set forth in Findings 11 and 12.

Cause Exists to Impose License Discipline

8. The clear and convincing evidence did not establish cause to impose discipline under the second cause for discipline (repeated negligent acts). The clear and convincing evidence did not establish that Dr. Buchbinder violated any standard of care by failing to obtain an anesthesia consult before or during Richard M.'s cardiac catheterization procedure, by the physical interaction with the patient occurring during the procedure, or by causing Narcan to be administered. While Dr. Buchbinder's comment to the patient in which he mentioned the breaking of the patient's arm during the interventional procedure was wholly inappropriate and fell below the standard of care, but extenuating circumstances excused this comment from being grounds to impose discipline.

This conclusion is based on the Factual Findings and Legal Conclusions set forth herein.

9. The clear and convincing evidence established cause to impose discipline under the first cause for discipline (gross negligence) and third cause for discipline (general unprofessional conduct) under Business and Professions Code section 2234. The clear and convincing evidence establish that while the patient was on the transfer gurney and was being observed by Cath Lab staff, Dr. Buchbinder yelled at the patient and said, "You are [acting like] an animal" and "If you keep this up I will not take care of you again," he grasped and twisted the patient's nose, he pinched the patient to cause pain, he lightly tapped the patient's face with a closed fist, and he bent the patient's wrist in a painful manner, all without any medical justification and as a result of his anger.

This conclusion is based on the Factual Findings and Legal Conclusions set forth herein.

The Appropriate Measure of Discipline

10. The uncontradicted expert testimony concerning Dr. Buchbinder's therapy and rehabilitation since the Cath Lab incident, when weighed against the wrongdoing occurring in the Cath Lab and all the inferences that should be drawn from it, established that a revocation, suspension, or period of probation is not required to protect the public and that the issuance of a public reprimand with conditions will adequately do so.
The issuance of a public reprimand in the matter, upon the condition that Dr. Buchbinder attend and complete a board-approved Ethics course within 90 days of the effective date of the decision in this matter and his agreement to participate in a one year board-approved educational program to further assist him in learning more about his personal anger management issues (which may take the form of psychotherapy or counseling) will adequately protect the public.

This conclusion is based on the Factual Findings and on the Legal Conclusions.

ORDER

The Decision in this matter constitutes the Public Reprimand in this matter, and it is conditioned upon Dr. Buchbinder completing a board-approved Ethics course within 90 days of the effective date of the Medical Board’s decision in this matter and Dr. Buchbinder’s agreement to complete a one year board-approved anger management program.

DATED: 2/18/10

JAMES AHLER
Administrative Law Judge
Office of Administrative Hearings