BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against IRINA V. VOLKOVA, M.D., Respondent.	**Case No. 14-38887-1**

FILED
SEP 17 2014
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee of the Nevada State Board of Medical Examiners (Board), composed of Theodore B. Berndt, M.D., Ms. Valerie J. Clark, BSN, RHU, LUTCF, and Michael J. Fischer, M.D., at the time of the authorization of filing this formal Complaint, by and through Edward O. Cousineau, Esq., Deputy Executive Director for the Board and counsel for the Investigative Committee, having a reasonable basis to believe that Irina V. Volkova, M.D., hereinafter referred to as "Respondent," has violated the provisions of Nevada Revised Statutes (NRS) Chapter 630, hereby issues its formal Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Respondent was licensed to practice medicine in the state of Nevada on January 10, 2012, Respondent's license to practice medicine is currently in active status, and at all times alleged herein, Respondent was licensed in active status by the Board pursuant to the provisions of Chapter 630 of the NRS.

2. On or about November 15, 2012, the California Medical Board filed a four-count Accusation against Respondent alleging various instances of unprofessional conduct on the part of Respondent (Exhibit 1). On or about September 3, 2013, a five-count First Amended Accusation

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Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
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was filed against Respondent alleging various instances of unprofessional conduct on the part of Respondent (Exhibit 2).

3. On January 31, 2014, a Decision of the California Medical Board (Exhibit 3) became effective. The Decision found Respondent grossly negligent in the treatment of a patient and that she had engaged in repeated negligent acts in relation to four separate patients. As a result, Respondent's license to practice medicine in the state of California was revoked, with the revocation being stayed and Respondent being placed on probation for three years along with numerous terms and conditions. Of note, Respondent never noticed the Board of the Decision entered by the state of California, or of the precedent investigation and prosecution related to the underlying Decision.

Count I

4. Section 630.301(3) of the NRS provides that any disciplinary action, including without limitation, the revocation, suspension, modification or limitation of a license to practice any type of medicine, taken by any other jurisdiction, is grounds for disciplinary action.

5. The disciplinary action related to Respondent's license to practice medicine in the state of California constitutes a violation of the provisions of NRS 630.301(3).

Count II

6. Section 630.306(11) of the NRS provides that the failure by a licensee to report in writing, within 30 days, any disciplinary action taken against the licensee by another state, is grounds for disciplinary action.

7. The failure of Respondent to report to the Board the disciplinary action in the state of California constitutes a violation of NRS 630.306(11).

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against her and give her notice that she may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

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3. That the Board determine the sanctions it will impose if it finds Respondent violated the Medical Practice Act; and

4. That the Board make, issue and serve on Respondent, in writing, its findings of fact, conclusions of law and order, which shall include the sanctions imposed.

DATED this 17th day of September, 2014.

INVESTIGATIVE COMMITTEE OF
THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Edward O. Cousineau, Esq.
Attorney for the Investigative Committee of the
Nevada State Board of Medical Examiners

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Theodore B. Berndt, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate, and correct.

Dated this 17th day of September, 2014.

Theodore B. Berndt

Theodore B. Berndt, M.D.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

CERTIFICATE OF SERVICE

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 18th day of September 2014; I served a filed copy of COMPLAINT and FINGERPRINT INFORMATION, USPS e-certified return receipt mail to the following:

Irina V. Volkova, M.D.
4425 Avondale Circle
Fairfield, CA 94533-9740

Dated this 18th day of September, 2014.

Angelia L. Donohoe
Legal Assistant

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
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EXHIBIT

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EXHIBIT

1

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **IRINA VOLKOVA, M.D.** 4425 Avondale Circle Fairfield, CA 94533 **Physician's and Surgeon's Certificate No. A 101170** Respondent.	Case No. 12-2011-219528 **ACCUSATION**

Complainant alleges:

PARTIES

1. Linda K. Whitney ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California.

2. On August 8, 2007, the Medical Board of California issued Physician's and Surgeon's certificate Number A 101170 to Irina Volkova, M.D. ("Respondent"). The Physician's and Surgeon's certificate was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2013, unless renewed.

JURISDICTION

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

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

5. Section 2234 of the Code provides in pertinent part that the Board "shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

6. "(a) Violating . . . any provision of this chapter.

"(b) Gross negligence.

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

"(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.

"(d) Incompetence.

" . . . ."

DRUGS

7. Amlodipine is in a class of medications called calcium channel blockers. It is a dangerous drug as defined in section 4022. Amlodipine lowers blood pressure by relaxing the blood vessels so the heart does not have to pump as hard. It controls chest pain by increasing the

supply of blood to the heart. If taken regularly, amlodipine controls chest pain, but it does not stop chest pain once it starts.

8. Clopidogrel, also known by the trade name Lasix, is in a class of medications called antiplatelet drugs. It is a dangerous drug as defined in section 4022. Clopidogrel works by helping to prevent harmful blood clots that may cause heart attacks or strokes.

9. Cozaar, a trade name for losartan, is in a class of medications called angiotensin II receptor antagonists. It is a dangerous drug as defined in section 4022. Cozaar works by blocking the action of certain natural substances that tighten the blood vessels, allowing the blood to flow more smoothly and the heart to pump more efficiently.

10. Dexamethasone, also known by the trade name Decadron, is a corticosteroid, similar to a natural hormone produced by the adrenal glands. It is a dangerous drug as defined in section 4022. It is used to replace the natural hormone when the body does not make enough of it and also relieves inflammation and is used to treat certain forms of arthritis; skin, blood, kidney, eye, thyroid, and intestinal disorders; severe allergies; and asthma. Corticosteroids may mask some signs of infection and new infections may appear during their use. There may be decreased resistance and inability to localize infection when corticosteroids are used. Dexamethasone is over 25 times more potent than hydrocortisone.

11. Hydrocortisone, a corticosteroid, is similar to a natural hormone produced by the adrenal glands. It is a dangerous drug as defined in section 4022. It is used to replace the natural hormone when the body does not make enough of it and also relieves inflammation and is used to treat certain forms of arthritis; skin, blood, kidney, eye, thyroid, and intestinal disorders; severe allergies; and asthma.

12. Lasix, a trade name for furosemide, is a diuretic used to treat edema and hypertension. It is a dangerous drug as defined in section 4022. Lasix is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required and dose schedule must be adjusted to the individual patient's needs. All patients receiving furosemide therapy should be observed for symptoms of fluid or electrolyte imbalance.

13. Lidoderm is a patch comprised of an adhesive material containing 5% lidocaine, an amide-type local anesthetic. Lidoderm is a dangerous drug as defined in section 4022. Each adhesive patch contains 700 mg of lidocaine (50 mg per gram adhesive) in an aqueous base. The penetration of lidocaine from the patch into intact skin after application of Liderderm is sufficient to produce an analgesic effect, but less than the amount necessary to produce a complete sensory block.

14. Lisinopril, also known by the trade names Prinivil and Zestril, is in a class of medications called angiotensin-converting enzyme (ACE) inhibitors. It is a dangerous drug as defined in section 4022. Lisinopril is used to treat hypertension and works by decreasing certain chemicals that tighten the blood vessels, so blood flows more smoothly and the heart can pump blood more efficiently. It is also used in combination with other medications to treat heart failure and to improve survival after a heart attack. Impaired renal function decreases elimination of lisinopril which is excreted principally through the kidneys.

15. Lovenox is a sterile aqueous solution containing enoxaparin sodium, a low molecular weight heparin. It is a dangerous drug as defined in section 4022. Lovenox is used for the prophylaxis of deep vein thrombosis and for the prophylaxis of ischemic complications of unstable angina and non-Q-wave myocardial infarction, when concurrently administered with aspirin. Lovenox should not be used in patients who are actively bleeding or who have a low count of blood cells called platelets, which aid in clotting.

16. Potassium chloride is used to prevent or to treat low blood levels of potassium (hypokalemia). It is a dangerous drug as defined in section 4022. Potassium is a mineral that is found in many foods and is needed for several bodily functions, especially the beating of the heart. Potassium levels can be low as a result of a disease, from taking certain medicines such as some diuretics, or after a prolonged illness with diarrhea or vomiting. To be sure potassium chloride is helping the condition being treated, blood levels may need to be tested often.

FACTS

17. At all times relevant to this matter, Respondent was licensed and practicing medicine in San Francisco, California.

PATIENT P-1[1]

18. On May 12, 2011, Patient P-1, a 60 year old woman with type 2 diabetes; hypertension; coronary artery disease, status post coronary artery bypass; peripheral vascular disease; chronic kidney disease; and congestive heart failure, was referred by the clinic to the Emergency Department ("ED"). She presented at 2:45 that afternoon with a two day history of headache and right arm weakness and numbness.

19. P-1 was admitted to the hospital at 9:09 p.m. with a diagnosis of acute ischemic stroke. She had ceased taking all medications one month prior to admission.

20. P-1's blood pressure on admission was 202/74. Her blood pressure readings improved over the next 24 hours. A noncontrast CT scan of the head revealed a hypodensity in the left pons and old lacunes in the left corona radiata and right basal ganglia. No bleeding was identified. An MRI confirmed an acute left pontine ischemic stroke and a subacute right parietal lobe stroke. P-1's blood was collected in the ED and blood tests reflected, among other things, a potassium level of 5.3, creatinine of 3.15, and a serum glucose of 270 mg/dL.

21. Respondent admitted P-1 to the hospital. She did not perform a neurological examination in her admission history and physical exam. Because Kaiser's only requirement is that its physicians complete a NIH systems score, she stated that that was all that she needed to do.

22. Respondent ordered all of Patient P-1's home medications restarted including the antihypertensive medications Cozaar 100 mg and Amlodipine 10 mg to be taken daily and insulin NPH 60 units to be taken twice a day. Respondent's decision to restart the medications was based on nephrology recommendations made a couple of years earlier. The dosage of insulin was based on a review of the record and P-1's report of the amount of insulin she had been taking before discontinuing all her medications. Another physician assumed P-1's care from Respondent the next day and discontinued the antihypertensive medications and reduced the

[1] The patients are designated in this document as Patients P-1 through P-4 to protect their and their families' privacy. Respondent knows the names of the patients and can confirm their identity through discovery.

insulin dose before P-1 had restarted any of the medications.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence; Incompetence)

23. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter), (b) (gross negligence), and (d) (incompetence), in that she ordered all of Patient P-1's outpatient antihypertensive medications restarted despite the patient's having a diastolic blood pressure below 120 and a systolic blood pressure below 220, thus putting her at risk of further neurological deterioration.

SECOND CAUSE FOR DISCIPLINE
(Gross Negligence; Incompetence)

24. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter), (b) (gross negligence), and (d) (incompetence), in that she put Patient P-1 at risk of persistent hypoglycemia by ordering her insulin restarted at the previous high dose despite her marked renal impairment and random glucose level of 270 mg/dL without having taken any insulin for a month.

PATIENT P-2

25. Patient P-2 presented to the ED on August 19, 2010 with atypical chest pain for one week. P-2 was a 93 year old female resident of an independent living facility with a history of depression, hypertension, hyperlipidemia, and diastolic heart failure, among other things. The ED noted no fevers, chills, or sweats. She did have back pain after, a week before, being forcefully pushed into a car she was trying to enter when the car moved.

26. Respondent saw P-2 at 9:01 p.m. August 19th. She performed a physical examination of the patient but failed to perform a rectal examination. She diagnosed P-2 with acute coronary syndrome and admitted her to the hospital. She started Patient P-2 on, among other things, the anticoagulants aspirin and clopidogrel, the ACE inhibitor lisinopril, and potassium chloride. Another anticoagulant, a therapeutic Lovenox (enoxaparin) injection, had been ordered in the ED approximately an hour earlier. Respondent ordered laboratory tests to be

done at 4:00 a.m. the next morning.

PATIENT P-3

27. Patient P-3, a 70 year old woman, was admitted to the hospital from the ED on July 25, 2010 after a fall, with diffuse abdominal pain and hematochezia (blood in stool). She had a history of coronary artery disease, atrial fibrillation, chronic obstructive pulmonary disease, hypertension, chronic kidney disease, and hyperlipidemia, among other things. She had a fever of 101 degrees. A CT scan revealed a distal transverse colitis and a chest x-ray revealed a right lower lobe infiltrate. She had elevated creatinine. She was started on Zosyn, a penicillin antibiotic, and stress-dose hydrocortisone.

28. Respondent assumed P-3's care on July 27, 2010. She diagnosed congestive heart failure based on, shortness of breath, wheezing, and a CT scan of the chest showing bilateral small pleural effusions. Respondent started P-3 on 40 mg intravenous injections of Lasix twice a day.

29. Respondent discharged P-3 on July 29, 2010. In addition to continuing P-3 on a number of the medications she had been taking, she ordered several new medications on discharge including two weeks of Lasix tablets, 40 mg/day, and potassium chloride, 40 MEq/day. She did not order follow-up potassium level testing.

PATIENT P-4

30. Respondent admitted Patient P-4, a 68 year old man, to the hospital from the ED at approximately 9:00 p.m. on December 23, 2010. He reported a 12 day history of fevers as high as 103 degrees and right low back pain radiating to the right buttock, right groin, and right thigh. He had recently been hospitalized and treated for pyelonephritis and was released six days before this admission. P-4 described the pain as being worse with weight bearing and ambulation and better when he sat or lay down. Respondent did not document or perform a back examination or a neurological examination. She diagnosed spinal stenosis with sciatica and a history of nephorlithiasis. She prescribed lidoderm patches for the pain and 4 mg intravenous dexamethasone for inflammation to be given every 6 hours. She ordered an MRI of the lumbosacral spine to be done the following day.

31. Initial laboratory tests were remarkable for a white blood count of 15.6, alkaline phosphatase of 409, a normal urinalysis, a markedly elevated erythrocyte sedimentation rate of 91, and a CT scan of the spine and hip revealing no signs of abscess, discitis, or osteomyelitis. A soft tissue mass near the right hip appeared unchanged from a scan done in 2005. Patient P-4 left the hospital against medical advice the next morning prior to the scheduled MRI. Two days later, he was readmitted with sepsis and a thigh abscess.

THIRD CAUSE FOR DISCIPLINE
(Gross Negligence)

32. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter) and, (b) (gross negligence), for failing to do a neurological examination and a back examination on Patient P-4 who was admitted for acute "sciatica."

FOURTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

33. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter), (c) (repeated negligent acts), in that she engaged in the following conduct:

1. She prescribed Cozaar, an antihypertensive medication that can increase potassium and transiently decrease renal function, for Patient P-1 despite her elevated creatinine level and reduced potassium level.
2. She ordered an ACE inhibitor and potassium chloride for Patient P-2 despite her reduced potassium level and compromised renal function.
3. She initiated and continued triple anticoagulant therapy for Patient P-2 without first assessing whether she had an occult GI bleed by way of a rectal examination or other means.
4. She failed to order Patient P-3's potassium level rechecked within a week of hospital discharge after having initiated a new diuretic regimen.

5. She administered steroids to Patient P-4 when it is likely that he had an occult infection.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 101170 issued to Irina Volkova, M.D.;

2. Revoking, suspending, or denying approval of Irina Volkova, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Irina Volkova, M.D., if placed on probation, to pay the costs of probation monitoring; and

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

DATED: November 15, 2012

LINDA K. WHITNEY
Executive Director
Medical Board of California
State of California
Complainant

Medical Board of California

I do herby Certify that this document is a true and correct copy of the original on file in this office.

Cliff Hamilton

Signature

For the Custodian of Records

Title

January 09, 2013.

Date

EXHIBIT

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EXHIBIT

2

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Attorney General of California
JOSE R. GUERRERO
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **IRINA VOLKOVA, M.D.** 2150 Rosa Rd. # C4A Schenectady, New York 12308 **Physician's and Surgeon's Certificate No. A 101170** Respondent.	Case No. 12-2011-219528 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On August 8, 2007, the Medical Board of California issued Physician's and Surgeon's certificate Number A 101170 to Irina Volkova, M.D. ("Respondent"). The Physician's and Surgeon's certificate was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2015, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Medical Board of California, under the authority of the following laws. All section references are to the Business and

Professions Code unless otherwise indicated.

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

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"(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.

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"(d) Incompetence.

" . . . ."

DRUGS

7. Amlodipine is in a class of medications called calcium channel blockers. It is a dangerous drug as defined in section 4022. Amlodipine lowers blood pressure by relaxing the

blood vessels so the heart does not have to pump as hard. It controls chest pain by increasing the supply of blood to the heart. If taken regularly, amlodipine controls chest pain, but it does not stop chest pain once it starts.

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for symptoms of fluid or electrolyte imbalance.

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FACTS

17. At all times relevant to this matter, Respondent was licensed and practicing medicine in San Francisco, California.

PATIENT P-1[1]

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19. P-1 was admitted to the hospital at 9:09 p.m. with a diagnosis of acute ischemic stroke. She had ceased taking all medications one month prior to admission.

20. P-1's blood pressure on admission was 202/74. Her blood pressure readings improved over the next 24 hours. A noncontrast CT scan of the head revealed a hypodensity in the left pons and old lacunes in the left corona radiata and right basal ganglia. No bleed was identified. An MRI confirmed an acute left pontine ischemic stroke and a subacute right parietal lobe stroke. P-1's blood was collected in the ED and blood tests reflected, among other things, a potassium level of 5.3, creatinine of 3.15, and a serum glucose of 270 mg/dL.

21. Respondent admitted P-1 to the hospital. She did not perform a neurological examination in her admission history and physical exam. Because Kaiser's only requirement is that its physicians complete a NIH systems score, she stated that that was all that she needed to do. Respondent did not document that an NIH evaluation was completed and did not document an NIH stroke score.

22. Respondent ordered all of Patient P-1's home medications restarted including the antihypertensive medications Cozaar 100 mg and Amlodipine 10 mg to be taken daily and insulin NPH 60 units to be taken twice a day. Respondent's decision to restart the medications was

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based on nephrology recommendations made a couple of years earlier. The dosage of insulin was based on a review of the record and P-1's report of the amount of insulin she had been taking before discontinuing all her medications. Another physician assumed P-1's care from Respondent the next day and discontinued the antihypertensive medications and reduced the insulin dose before P-1 had restarted any of the medications.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence; Incompetence)

23. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter), (b) (gross negligence), and (d) (incompetence), in that she ordered all of Patient P-1's outpatient antihypertensive medications restarted despite the patient's having a diastolic blood pressure below 120 and a systolic blood pressure below 220, thus putting her at risk of further neurological deterioration.

SECOND CAUSE FOR DISCIPLINE
(Gross Negligence; Incompetence)

24. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter), (b) (gross negligence), and (d) (incompetence), in that she put Patient P-1 at risk of persistent hypoglycemia by ordering her insulin restarted at the previous high dose despite her marked renal impairment and random glucose level of 270 mg/dL without having taken any insulin for a month.

THIRD CAUSE FOR DISCIPLINE
(Gross Negligence)

25. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter), (b) (gross negligence), and (d) (incompetence), in that she failed to do a neurological examination or even to calculate an NIH stroke score for a patient, Patient P-1, admitted to the hospital for acute ischemic stroke.

PATIENT P-2

26. Patient P-2 presented to the ED on August 19, 2010 with atypical chest pain for one week. P-2 was a 93 year old female resident of an independent living facility with a history of depression, hypertension, hyperlipidemia, and diastolic heart failure, among other things. The ED noted no fevers, chills, or sweats. She did have back pain after, a week before, being forcefully pushed into a car she was trying to enter when the car moved.

27. Respondent saw P-2 at 9:01 p.m. August 19th. She performed a physical examination of the patient but failed to perform a rectal examination. She diagnosed P-2 with acute coronary syndrome and admitted her to the hospital. Before obtaining the results of laboratory tests that she ordered to be drawn at 4:00 a.m. the following morning, Respondent ordered, among other things, that P-2 be started on the anticoagulants aspirin and clopidogrel, the ACE inhibitor lisinopril, and potassium chloride. Another anticoagulant, a therapeutic Lovenox (enoxaparin) injection, had been ordered in the ED approximately an hour earlier.

PATIENT P-3

28. Patient P-3, a 70 year old woman, was admitted to the hospital from the ED on July 25, 2010 after a fall, with diffuse abdominal pain and hematochezia (blood in stool). She had a history of coronary artery disease, atrial fibrillation, chronic obstructive pulmonary disease, hypertension, chronic kidney disease, and hyperlipidemia, among other things. She had a fever of 101 degrees. A CT scan revealed a distal transverse colitis and a chest x-ray revealed a right lower lobe infiltrate. She had elevated creatinine. She was started on Zosyn, a penicillin antibiotic, and stress-dose hydrocortisone.

29. Respondent assumed P-3's care on July 27, 2010. She diagnosed congestive heart failure based on, shortness of breath, wheezing, and a CT scan of the chest showing bilateral small pleural effusions. Respondent started P-3 on 40 mg intravenous injections of Lasix twice a day.

30. Respondent discharged P-3 on July 29, 2010. In addition to continuing P-3 on a number of the medications she had been taking, she ordered several new medications on discharge including two weeks of Lasix tablets, 40 mg/day, and potassium chloride, 40 MEq/day.

She did not order follow-up potassium level testing.

PATIENT P-4

31. Respondent admitted Patient P-4, a 68 year old man, to the hospital from the ED at approximately 9:00 p.m. on December 23, 2010. He reported a 12 day history of fevers as high as 103 degrees and right low back pain radiating to the right buttock, right groin, and right thigh. He had recently been hospitalized and treated for pyelonephritis and was released six days before this admission. P-4 described the pain as being worse with weight bearing and ambulation and better when he sat or lay down. Respondent did not document or perform a back examination or a neurological examination. She diagnosed spinal stenosis with sciatica and a history of nephorlithiasis. She prescribed lidoderm patches for the pain and 4 mg intravenous dexamethasone for inflammation to be given every 6 hours. She ordered an MRI of the lumbosacral spine to be done the following day.

32. Initial laboratory tests were remarkable for a white blood count of 15.6, alkaline phosphatase of 409, a normal urinalysis, a markedly elevated erythrocyte sedimentation rate of 91, and a CT scan of the spine and hip revealing no signs of abscess, discitis, or osteomyelitis. A soft tissue mass near the right hip appeared unchanged from a scan done in 2005. Patient P-4 left the hospital against medical advice the next morning prior to the scheduled MRI. Two days later, he was readmitted with sepsis and a thigh abscess.

FOURTH CAUSE FOR DISCIPLINE
(Gross Negligence)

33. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter) and, (b) (gross negligence), for failing to do a neurological examination and a back examination on Patient P-4 who was admitted for acute "sciatica."

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FIFTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

34. Respondent's license is subject to disciplinary action for unprofessional conduct in violation of section 2234, subdivisions (a) (violating provisions of this chapter), (c) (repeated negligent acts), in that she engaged in the following conduct:

1. She prescribed Cozaar, an antihypertensive medication that can increase potassium and transiently decrease renal function, for Patient P-1 despite her elevated creatinine and potassium levels.
2. She ordered an ACE inhibitor and potassium chloride for Patient P-2 before obtaining laboratory test results showing P-2's baseline potassium level and renal function.
3. She initiated and continued triple anticoagulant therapy for Patient P-2 without first assessing whether she had an occult GI bleed by way of a rectal examination or other means.
4. She failed to order Patient P-3's potassium level rechecked within a week of hospital discharge after having initiated a new diuretic regimen.
5. She administered steroids to Patient P-4 when it is likely that he had an occult infection.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 101170 issued to Irina Volkova, M.D.;

2. Revoking, suspending, or denying approval of Irina Volkova, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Irina Volkova, M.D., if placed on probation, to pay the costs of probation monitoring; and

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

DATED: September 3, 2013

KIMBERLY KIRCHMEYER
Interim Executive Director
Medical Board of California, State of California
Complainant

EXHIBIT 3

EXHIBIT 3

L.I file# 38587

copy - 12-14223
copy - L. file

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

In the Matter of the Accusation Against:	)	
IRINA VOLKOVA, M.D.	)	**MBC No. 12-2011-219528**
Physician's & Surgeon's Certificate No. A 101170	)	
Respondent.	)	

ORDER GRANTING STAY

The Medical Board of California (Board) has filed a Request for a Stay of execution of the Decision in this matter with an effective date of January 23, 2014.

Execution is stayed until **January 31, 2014.**

This stay is granted solely for the purpose of allowing the Board time to review a Petition for Reconsideration.

DATED: **January 17, 2014.**

A. Renee Threadgill

A. Renee Threadgill
Chief of Enforcement
Medical Board of California

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

In the Matter of the Accusation Against:	
IRINA VOLKOVA, M.D.	**Case No. 12-2011-219528**
	OAH No. 2013030726
Physician's and Surgeon's Certificate No. A 101170	
Respondent.	

DECISION

The attached Proposed Decision is hereby adopted by the Medical Board of California, Department of Consumer Affairs, State of California, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on January 23, 2014.

IT IS SO ORDERED December 24, 2013.

MEDICAL BOARD OF CALIFORNIA

By: Dev Gnanadev MD
Dev Gnanadev, M.D., Chair
Panel B

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

In the Matter of the Accusation Against:	
IRINA VOLKOVA, M.D.	Case No. 12-2011-219528
Physician's and Surgeon's Certificate No. A101170	OAH No. 2013030726
Respondent.	

PROPOSED DECISION

Administrative Law Judge Mary-Margaret Anderson, Office of Administrative Hearings, State of California, heard this matter on September 30 and October 1, 2013, in Oakland, California.

Kerry Weisel, Deputy Attorney General, represented Complainant Kimberly Kirchmeyer, Interim Executive Director of the Medical Board of California.

Courtney E. Pilchman, Attorney at Law, represented Respondent Irina Volkova, M.D., who was present.

The record remained open to allow the parties to file written closing argument. The briefs were timely filed and marked for identification as follows: Complainant's Closing Argument-Opening Brief, Exhibit 12; Respondent's Closing Argument, Exhibit G; and Complainant's Closing Argument-Reply Brief, Exhibit 13.

The record closed on October 28, 2013.

FACTUAL FINDINGS

1. Complainant Kimberly Kirchmeyer issued the Accusation in her official capacity as Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On August 8, 2007, the Board issued Physician's and Surgeon's Certificate No. A101170 to Irina Volkova, M.D. (Respondent). It will expire on February 28, 2015, unless renewed.

3. The Accusation alleges that Respondent, while serving as a hospitalist, committed unprofessional conduct (gross negligence, repeated acts of negligence and incompetence) in the treatment of four patients. Respondent filed a Notice of Defense and this hearing followed.

4. The standard of proof applied in making the factual findings is clear and convincing evidence to a reasonable certainty.

Respondent's background

5. Respondent received her medical degree and a doctorate in philosophy from Danylo National Medical University in Lviv, Ukraine. She was an Attending Physician and Associate Professor of Obstetrics and Gynecology in Ukraine from 1987 to 1997. Dr. Volkova had also been a registered nurse in Ukraine, and first worked in that capacity when she moved to the United States. In 2008, she completed a family medicine residency at the University of Buffalo, Niagara Falls Memorial Medical Center in New York. Dr. Volkova worked as a hospitalist at Niagara Falls Memorial Medical Center from June 30, 2008, until April 28, 2010.

This matter concerns Respondent's work as a hospitalist at Kaiser Permanente's hospital in Vallejo, where she was employed from May 2010 until November 2011. From December 2011 until April 2012, Respondent worked in locum tenens positions in the Stockton area. Since May 18, 2012, she has worked as a hospitalist at Ellis Hospital in Schenectady, New York.

Expert opinion evidence

6. Joseph S. Esherick, M.D., received his medical degree from the Yale University School of Medicine in 1994. He completed a family practice residency in 1997, and is board certified in family practice. Dr. Esherick has been employed by the Ventura County Medical Center as a hospitalist since 1998, except for a one-year period when he practiced with a group in Ukiah. He became a fellow in the American Academy of Family Practice in 2005.

Dr. Esherick currently works as a hospitalist, which he describes as a specialist who admits patients to the hospital and cares for them until they are discharged. Ventura Hospital is affiliated with the University of California, Los Angeles (UCLA). Dr. Esherick is an adjunct professor at UCLA, and supervises three family practice residents.

7. Richard Johnson, M.D., received his medical degree from the Washington University School of Medicine in 1977. He completed a family practice residency in 1980, and has been board certified in family practice since 1981. Dr. Johnson joined the faculty at

UCLA Medical School in 1980, and holds a full professorship. He left the full-time faculty in 2004, and now has a private practice affiliated with UCLA. He teaches medical students during their family practice rotation.

Dr. Johnson has never worked as a hospitalist, which he describes as a recent specialty that is more of a business model, and only about ten years old. For approximately 20 years he saw patients in a hospital setting at Ronald Reagan UCLA Medical Center. He followed the patients, however, "for social reasons"; he did not provide care while they were hospitalized. Dr. Johnson has not had any education or taught specifically about managing hospitalized patients. Asked the last time he provided acute management for a stroke patient, he replied that it was recently, but that the management consisted of sending the patient to the hospital. Dr. Johnson is highly qualified in the specialty of family medicine in an outpatient context.

Analysis of expert opinions

8. Both expert witnesses are highly knowledgeable and skilled family medicine practitioners. They practice, however, in two very different environments, and their backgrounds in that regard are very different. Dr. Esherick is a very experienced hospitalist, and Dr. Johnson has never practiced in that setting.

Dr. Johnson expressed opinions based upon what he asserted is the common practice in hospitals. These included how often patients are monitored and tested, the responsibilities of nursing staff, and broad statements such as that because of the practice setting, a hospitalist such as Respondent is "entitled to rely" on other members of the hospital team for various things. Because of his lack of direct experience as a hospitalist, his opinions were accorded less weight.

For the above-described reasons, the opinions of Dr. Esherick were generally more persuasive than those of Dr. Johnson. The findings concerning the four patients are therefore primarily informed by Dr. Esherick's opinions.

Patient No. 1

9. On May 12, 2011, at 2:45 p.m., P-1,[1] a 66-year-old female, presented to the Kaiser Vallejo[2] Emergency Department (ED), following referral from the clinic. Her history included type 2 diabetes, hypertension, coronary artery disease, status post-coronary artery bypass, peripheral vascular disease, chronic kidney disease, and congestive heart failure. She had ceased taking all medications one month prior. She reported a two-day history of headache and right arm weakness and numbness.

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[1] Patients are referred to by numbers to protect privacy.

[2] All patient care took place at Kaiser Permanente Vallejo.

Respondent admitted P-1 to the hospital at 9:09 p.m. On admission, P-1's blood pressure was 202/74. A noncontact CT scan of the head revealed a hypodensity in the left pons and old lacunar infarcts in the left corona radiata and right basal ganglia. No bleed was identified. An MRI confirmed an acute left pontine ischemic stroke and a subacute right parietal lobe stroke. Blood tests revealed a potassium level of 5.3, creatinine of 3.15, and a serum glucose of 270 mg/dL. The diagnosis on admission was acute ischemic stroke.

10. Respondent did not perform a complete neurological examination. She asserts that she completed an NIH systems score, but did not document the evaluation or an NIH stroke score. Respondent ordered all of P-1's previously prescribed medications, including antihypertensive medications Cozaar 100 mg and Amlodipine 10 mg, to be taken daily, and insulin NPH 60 units to be taken twice daily. The physician who assumed care of P-1 the following day discontinued the antihypertensive medications and reduced the insulin dose before P-1 had taken any of the medications prescribed by Respondent.

--- *Allegation 1*

11. Complainant alleges that Respondent's care of P-1 constituted gross negligence and/or incompetence in that she ordered all of P-1's previously ordered hypertensive medications restarted. P-1's diastolic blood pressure was below 120 and her systolic blood pressure was below 220, which put her at risk of further neurological deterioration.

12. Respondent's orders were for three hypertensive medications, two at their maximum dosage. The standard of practice in this instance is reflected in the 2007 guidelines issued by the American Stroke Association, which warn against rapidly lowering blood pressure in the early management of an acute ischemic stroke. Both expert witnesses agree that this was a departure from the standard of practice, with Dr. Esherick opining that the departure was extreme.

Dr. Esherick's opinion that the departure was extreme is not persuasive. The evidence established that Respondent's conduct involved simple negligence and incompetence.

--- *Allegation 2*

13. Complainant alleges that Respondent's care of P-1 constituted gross negligence and/or incompetence in that she put P-1 at risk of persistent hypoglycemia. Respondent ordered P-1's insulin restarted at the previous high dose, despite two facts: her marked renal impairment and that she had a random glucose level of 270 mg/dL without having taken any insulin for one month.

14. As she did with the medications for hypertension, Respondent ordered the same insulin dose for P-1 that she reported receiving prior to her stroke. Respondent asserts this decision was acceptable, in large part because of the frequent blood sugar monitoring that occurs in the acute hospital setting, allowing for frequent adjustments in dosage and medication. Dr. Johnson's opinions as regards normal practice in a hospital setting, for example, that

Respondent "had every right to assume this patient's blood sugar would be checked frequently," are accorded little weight, given his lack of experience in the hospital setting as opposed to that of Dr. Esherick.

15. Dr. Esherick's opinion was persuasive that the standard of care would be to start with small amounts of basal insulin and prandial insulin lispro as needed for hyperglycemia at mealtimes. High amounts of insulin following no medications for one month in a patient with Stage IV or V chronic kidney disease would likely have caused hypoglycemia. In addition, Respondent ordered that P-1's glucose be monitored only four times a day, and P-1 could have gone into a diabetic coma in between monitoring times. The evidence established that Respondent's conduct was an extreme departure from the standard of care and incompetent.

--- *Allegation 3*

16. Complainant alleges that Respondent's care of P-1 constituted gross negligence and/or incompetence in that she failed to do a neurological examination or calculate a National Institute of Health Stroke Severity Scale (NIH stroke score) despite P-1's hospital admission for acute ischemic stroke.

17. The NIH stroke score is an 11-point system for scoring the level of impairment caused by a stroke. Respondent claims she did such a scoring, which is required by Kaiser. But if she did complete this task, it is not clear where she documented it. Respondent had trouble with Kaiser's electronic record system, and during her interview suggested that she placed some current information in the history section of the record, but this information could not be located.

Respondent asserts that such scoring is all that was required in this instance, because she could rely on the neurological examination performed by the ED physician, Dr. Chu, whom she also argues was the admitting physician. This is incorrect; as noted above, Respondent admitted P-1 to the hospital, and Dr. Chu performed only a limited examination.

18. Dr. Johnson opined in addition that nursing staff will complete some stroke scales. His opinion as regards hospital practice, however, is negatively impacted by his lack of experience as a hospitalist, contrary to the extensive experience of Dr. Esherick.

19. Dr. Esherick opined that it was Respondent's responsibility to complete a full neurological examination of P-1, a stroke patient. Following this, subsequent treaters may perform abbreviated examinations, but it is very important to have and document a complete baseline of information. Thus, the patient's progress, or lack of progress, during her hospitalization can be monitored. Dr. Esherick's opinion was persuasive, but established a simple departure, not gross negligence in this instance. Incompetence was also established.

--- *Allegation 4*

20. Complainant alleges that Respondent was negligent in her care of P-1 in that she prescribed Cozaar, an antihypertensive medication that can increase potassium and transiently decrease renal function despite P-1's elevated creatinine and potassium levels.

21. Cozaar (losartan) is an angiotensin receptor blocker. P-1's blood test results showed a high normal potassium level of 5.3 and elevated creatinine of 3.15, and she had at least Stage 4 kidney disease. Given these conditions, Cozaar could have elevated the creatinine and potassium levels, further decreasing renal function. Respondent again relies on her assumption that there will be frequent monitoring and that she did not order anything that P-1 had not received before. Dr. Esherick's opinion that this was a simple departure was persuasive.

Patient No. 2

22. On August 19, 2010, P-2, a 93-year-old female resident of an independent living facility, presented to the Emergency Department with atypical chest pain for one week. No fevers, chills, or sweats were noted. One week prior she experienced back pain after being pushed into a car. Her history included depression, hypertension, hyperlipidemia (excess fats or lipids in the blood), and diastolic heart failure.

Respondent saw P-2 at 8:49 p.m. She performed a physical examination that did not include a rectal exam, and diagnosed acute coronary syndrome. Respondent admitted P-2 at approximately 9:00 p.m. and started her on a variety of medications.

--- *Allegation 1*

23. Complainant alleges that Respondent was negligent in her care of P-2 in that she ordered an ACE inhibitor and potassium chloride for her before obtaining laboratory test results showing her baseline potassium level and renal function.

24. Respondent ordered baseline labs at approximately 4:30 a.m. on August 20. She went off duty at 7:00 a.m., and did not have the results before ordering medications that included an ACE inhibitor and potassium chloride. (Another anticoagulant, a therapeutic Lovenox (enoxaparin) had been ordered in the ED approximately one hour earlier.) Dr. Esherick opined that these medications should not be ordered before the test results are known, as there is no urgency to do so. P-2's admission blood pressure readings ranged from 122/79 to 130/53. Increased potassium levels can cause cardiac arrhythmia or arrest, and affect renal function, which in P-2 was already impaired. Dr. Johnson opined that it was acceptable to order the medications because of a note in the ED record that the labs were "okay" and because P-2's records showed she had taken them previously.

The difference of opinion is grounded in a different view of the correct standard of practice for a hospitalist. In part because of Dr. Esherick's expertise in that area, a simple

departure from the standard of care is found in the orders for an ACE inhibitor and potassium chloride in these circumstances.

--- *Allegation 2*

25. Complainant alleges that Respondent was negligent in her care of P-2 in that she initiated and continued triple anticoagulant therapy for her without first assessing whether she had an occult GI bleed by way of a rectal examination or other means.

26. Because anticoagulants can worsen internal bleeding, it is the standard of practice to screen for signs of internal bleeding prior to initiating anticoagulation therapy. Stable vital signs are not sufficient, nor is the absence of abdominal pain. Respondent's records do not indicate that she screened for bleeding, whether by checking the stool, or ordering a urinalysis. Dr. Johnson asserts that a rectal examination would have been dangerous, because of the possibility of a vagal reaction, not to mention the discomfort that such examination generally causes. Dr. Johnson, however, is an outpatient clinician who does not order triple anticoagulation therapy, and is therefore not an expert in the standard of care. Dr. Esherick's opinion that a rectal examination is routine, and can be performed in a gentle manner that is not harmful, was persuasive. It was established that Respondent's failure in this instance was a simple departure from the standard of care.

Patient No. 3

27. On July 25, 2010, P-3, a 70-year-old female, was admitted to the hospital from the ED. She had suffered a fall, and had diffuse abdominal pain and hematochezia (blood in stool). P-3's history included coronary artery disease, atrial fibrillation, chronic obstructive pulmonary disease, hypertension, chronic kidney disease, and hyperlipidemia. A CT scan revealed a distal transverse colitis and a chest x-ray revealed a right lower lobe infiltrate.

Respondent assumed care of P-3 on July 27, and discharged her on July 29. She had diagnosed congestive heart failure, and medications on discharge included a new course of Lasix 40 mg per day for two weeks and potassium chloride 40 MEq/day for two weeks. Respondent made an appointment for P-3 to see her primary care physician in two weeks.

--- *Allegation 1*

28. Complainant alleges that Respondent was negligent in her care of P-3 in that she failed to order her potassium level rechecked within a week of discharge, after having initiated a new diuretic regimen.

Respondent asserts that diuretics such as Lasix may potentially reduce potassium levels, but not in a short period of time. Nonetheless, she prescribed potassium along with the Lasix, and obtained the follow up appointment for her. Dr. Johnson and Respondent pointed out that the manufacturer's guidelines for Lasix do not state that patients should be evaluated within one week, and Respondent further testified that she has never heard of this. She also stated that she

was unaware of how to order labs on an outpatient basis at that point in her employment with Kaiser.

Dr. Esherick articulated a straightforward opinion that was persuasive given his level of expertise. It was established therefore that Respondent's failure to order a recheck of P-3's potassium level within one week was a simple departure from the standard of care.

Patient No. 4

29. On December 23, 2010, P-4, a 68-year-old male presented to the ED. He had been recently hospitalized for six days with pyelonephritis (a kidney infection). Respondent admitted P-4 at approximately 9:00 p.m. Her notes include: "Pt continue to have fevers at home with elevated temp up to 102-103 at night. He also continue to c/o of back pain with radiation to the middle of the buttock on the right, groin area and thigh on the right. The pain exacerbated with walking and partially relieved with sitting or lying down." Respondent did not document a neurological or back examination. She diagnosed spinal stenosis, prescribed a steroid (dexamethasone) for pain, and ordered an MRI of the lumbosacral spine for the following day.

30. Initial lab tests were remarkable for an elevated white blood cell count of 15.6, elevated alkaline phosphatases, a normal urinalysis and a markedly elevated erythrocyte sedimentation rate of 91.

31. P-4 self-discharged the following day, contrary to medical advice and prior to the MRI. He was readmitted two days later with sepsis and a thigh abscess.

--- *Allegation 1*

32. Complainant alleges that Respondent was grossly negligent for failing to do a neurological examination and a back examination on P-4, who was admitted for acute sciatica.

33. Respondent asserts that she performed a physical examination that included a back examination. She had the patient walk and lie down, and assessed his buttocks, groin, and right thigh. She also checked the neurological exam report, which "had just been done." Respondent documented these activities in a different part of the record, because she did not know how to open the correct template. She states that she recorded some of her own observations in the patient history section. She also testified that "you have to open a special template for the score for the NIHSS," which she "did for this patient." It is unclear to what extent Respondent was not competent to utilize the electronic medical records system. Respondent defended the diagnosis of sciatica, describing it as "a clinical approach to determine the cause of back pain."

Dr. Johnson opined that sciatica is a general diagnosis, a generic term for the type of pain that begins in the buttocks and goes down the leg. The pain that P-4 described was consistent with sciatica. He appeared to discount the reports of fever in the record.

34. Dr. Esherick faults Respondent for completely misdiagnosing P-4. Among other things, he noted that very few conditions cause a sedimentation rate of 91, and sciatica is not one of them. Specifically, he opined that failing to perform a neurological and back examination was an extreme departure, not excused by lack of familiarity with the electronic medical records system. Given the history of fevers, reports of pain, and lab results, an occult infection should have been a serious concern. The various components of a neurological examination provide essential information to assist in arriving at a differential diagnosis, and such is the standard of care for a hospitalist in these circumstances.

35. It is determined that an extreme departure was not established. In this regard it is noted that several other physicians were involved in the diagnosis and care of P-4, that another physician documented a neurological exam, and that evaluation of the patient was ongoing when he self-discharged. Respondent's failure to conduct her own examinations was a simple departure in these circumstances.

--- *Allegation 2*

36. Complainant alleges that Respondent was negligent by administering steroids to P-4, when it is likely that he had an occult infection.

37. The opinion of Dr. Esherick that the prescription of steroids is contra-indicated in the presence of an infection, which was highly likely in the case of P-4, was persuasive. Steroids can worsen an infection, and nonsteroidal anti-inflammatories (or other medications) could have been prescribed for pain. Until an infection could be ruled out, steroids should not be prescribed. Respondent's assertion that steroids are commonly given for pain may be true, but is not relevant in these circumstances. A simple departure from the standard of care was established.

Respondent's evidence

38. Respondent submitted in evidence several letters of reference and a few performance evaluations. Two very strong letters concerning her current employment at Ellis Hospital in Schenectady, New York, were received. Ivan Shvachuk, M.D., Medical Director, Department of Hospitalist Medicine wrote a letter dated September 6, 2013. He has worked with Respondent since May 2012. In pertinent part, Dr. Shvachuk wrote:

> [Respondent] has an excellent knowledge base and has had a wide range of clinical experience. She stays abreast of new publications. [Respondent] works with an ever-changing range of patient illness and is on top of each diagnosis.
>
> A chart review performed by myself and the Chief Medical Officer, Dave Liebers, M.D., revealed excellent clinical judgment, documentation written in a comprehensive manner, with no deficiencies evident.

Carolyn Jones-Assini, M.D., is the Chair of Internal Medicine. In a letter dated September 24, 2013, she described Ellis Hospital in detail, including that it is a 438-bed community and teaching hospital with a 35-unit ICU. The team of hospitalists attend or are consulted with over 80 percent of patients, and they co-manage the orthopedic, neurology, and most of the surgical patients. In pertinent part, Dr. Jones-Assini described Respondent as invaluable, and as

> a physician who cares effectively for her patients and works in concert with her colleagues. From our first consideration of her application to join our team, [Respondent] has shared the concerns raised from her previous employer. After thoroughly reviewing the cases presented by the California Review Board, and speaking with the Kaiser Chief Medical Officer, we did not find substance to the charges. As the Review Board has progressed, she has continued to keep us informed and asked that we send comments concerning her performance to date.
>
> As Chair of Internal Medicine, I fully support [Respondent] being cleared of these charges, because of her witnessed performance for the past 18 months at Ellis Medicine.

39. Other letters are complimentary of Respondent's work in her residency program at Niagara Falls Memorial Medical Center and at Kaiser Vallejo. A certificate of credit verifies Respondent's participation in a course on the NIH Stroke Scale in 2010.

LEGAL CONCLUSIONS

1. Unprofessional conduct is grounds for discipline of a physician's certificate pursuant to Business and Professions Code section 2234. Unprofessional conduct includes gross negligence (Bus. & Prof. Code § 2234, subd. (b)), repeated negligent acts (Bus. & Prof. Code § 2234, subd. (c)), and incompetence (Bus. & Prof. Code, § 2234, subd. (d)).

2. The evidence established that Respondent was grossly negligent in the treatment of P-1. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (b), by reason of the matters set forth in Findings 13 through 15.

3. The evidence established that Respondent committed repeated negligent acts, in that simple departures from the standard of care were found in her treatment of all four patients. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (c), by reason of the matters set forth in Findings 11, 12, 16 through 21, 23 through 26, 28, and 32 through 37.

4. In the context of professional licensing, "incompetence" means "a lack of knowledge or ability in the discharging of professional obligations. Often, incompetence results from a correctable fault or defect." (*James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109.) The evidence demonstrates that Respondent lacked competence in her treatment of P-1. Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (d), by reason of the matters set forth in Findings 11 through 19.

5. As cause for discipline has been established, it remains to determine the appropriate level of discipline to impose. The purpose of these proceedings is to protect the public, but it is also to remediate physicians when appropriate. It was troubling that Respondent sought to some extent to blame or explain her practice deficiencies on the systems in place at the hospital where she worked. A lack of experience with a new medical record keeping system is understandable, but the solution is to ask for help or record notes on paper, not to fail entirely to document care. The reference letters submitted on Respondent's behalf speak to her ability to practice at a higher level than she exhibited at Kaiser Vallejo. It is also noted that Complainant recommends a term of probation. It is concluded that the public interest will be served and protected, and that Respondent's practice will be aided, by a three-year term of probation under the terms and conditions ordered below.

ORDER

Physician's and Surgeon's Certificate No. A101170, issued to Respondent Irina Volkova, M.D., is revoked; however, revocation is stayed and Respondent is placed on probation for three years upon the following terms and conditions.

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping, at Respondent's expense, approved in advance by the

Board or its designee. Failure to successfully complete the course during the first six months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Monitoring – Practice

Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name, and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision, and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, Respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within three calendar days after being so notified by the Board or designee.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

4. Notification

Prior to engaging in the practice of medicine Respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities, or insurance carrier.

5. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

6. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court-ordered criminal probation, payments, and other orders.

7. Quarterly Declarations

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

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. Probation Unit Compliance

Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board or its designee.

Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Respondent shall not engage in the practice of medicine in Respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's certificate.

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

9. Interview with the Board or its Designee

Respondent shall be available in person for interviews either at Respondent's place of business or at the probation unit office, with the Board or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

10. Residing or Practicing Out-of-State

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of

this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Probation Monitoring Costs.

Respondent's certificate shall be automatically cancelled if Respondent's periods of temporary or permanent residence or practice outside California total two years. However, Respondent's certificate shall not be cancelled as long as Respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two-year period shall begin on the date probation is completed or terminated in that state.

11. Failure to Practice Medicine - California Resident

In the event Respondent resides in the State of California and for any reason Respondent stops practicing medicine in California, Respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve Respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's certificate shall be automatically cancelled if Respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

12. Completion of Probation

Respondent shall comply with all financial obligations (e.g., probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

13. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request the voluntary surrender of Respondent's license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet card and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of Respondent's license shall be deemed disciplinary action. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

15. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

DATED: [illegible]

MARY-MARGARET ANDERSON
Administrative Law Judge
Office of Administrative Hearings