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

In the Matter of the Accusation Against:  

SUPRABHA JAIN, M.D.  
Physician's and Surgeon's  
Certificate No. A-67699  

Respondent.  

____________________________________  

Case No. 12-2009-197864

DENIAL BY OPERATION OF LAW
PETITION FOR RECONSIDERATION

No action having been taken on the petition for reconsideration, filed by Robert W. Hodges, Esq., on behalf of respondent Suprabha Jain, M.D., and the time for action having expired at 5 p.m. on April 7, 2014, the petition is deemed denied by operation of law.
Robert W. Hodges, Attorney at Law, on behalf of Suprabha Jain, M.D., has filed a Request for Reconsideration of the Decision in this matter with an effective date of March 28, 2014.

Execution is stayed until April 7, 2014.

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

DATED: March 28, 2014

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:  

SUPRABHA JAIN, M.D.,  
Case No. 12-2009-197864  

Physician and Surgeon’s Certificate No.  
A 67699  
OAH No. 2012070765  
Respondent.  

DECISION AFTER NONADOPTION  

Administrative Law Judge Ruth S. Astle, State of California, Office of Administrative Hearings, heard this matter in Oakland, California on May 13, 14, 15, 16 and June 19 and 20, 2013.  

Vivian Hara, Deputy Attorney General, represented complainant.  

Respondent Suprabha Jain, M.D., was present and represented by Robert W. Hodges, Attorney at Law.  

Submission of the matter was deferred for receipt of final arguments, which were received and considered. The matter was submitted on August 21, 2013.  

Panel A of the Medical Board of California (Board) declined to adopt the proposed decision issued on September 20, 2013, and issued an Order of Non-Adoption of Proposed Decision on November 14, 2013. On January 3, 2014, the Board issued a Notice of Hearing for Oral Argument, and fixed the date for argument on February 6, 2014. The Panel, having read and considered the entire record, including the transcripts and the exhibits, and having considered the written and oral arguments presented by respondent and complainant, hereby makes and enters this decision on the matter.  

FACTUAL FINDINGS  

1. Complainant Kimberly Kirchmeyer made this accusation in her official capacity as the Interim Executive Director of the Board.
2. On March 5, 1999, Physician and Surgeon’s Certificate No. A 67699 was issued by the Board to Suprabha Jain, M.D. (respondent). Respondent’s certificate will expire March 31, 2015, unless renewed.

Respondent has not been the subject of prior disciplinary action.

_Gross Negligence/Negligence/Incompetence -Patient K.S._

3. K.S. first consulted respondent at Mt. Diablo Wellness Center, Inc. (MDI) on January 4, 2009. K.S. had issues with anxiety, depression, and pain since she was 28 years old. She had consulted an acupuncturist and a chiropractor. She was also a patient of an integrative pain management clinic in Concord, California. Respondent was never K.S.’s primary care physician. K.S. suffered from chronic neck and low back pain; her weight was 210 pounds at the time she first consulted respondent. She also complained of always being cold and sleeping 14 hours a day. She indicated on her MDI patient information sheet that her reason for consulting respondent was “sweats and muscle spasm.”

4. K.S. reported that in the previous year, she had decided to reduce or eliminate a number of drugs she was taking for her medical conditions. Her prescribed drugs included Advair, albuterol, Xanax, Dilaudid, Oxycodone, Effexor, Abilify, Klonopin, fentanyl patches, and a stool softener. She had been reducing or eliminating the drugs by herself without medical supervision. She stopped using all prescribed medications except Klonopin and fentanyl patches at the time she consulted respondent.

5. When K.S. began suffering from sweats and nausea, her son recommended respondent’s clinic. K.S.’s mother had been respondent’s patient previously and had $5,000 in unapplied deposits reserved at MDI. K.S. called MDI and was able to make an appointment with respondent for the next day, January 4, 2009. K.S. filled out a patient information sheet and was examined by respondent. Respondent recognized that K.S. was suffering the effects of narcotics/controlled substance withdrawal.

6. Respondent developed a “medical model” form for intake history and physical. On January 4, 2009, K.S. filled out the first page of a patient information form; the second page was left blank. Respondent recorded a brief medical history of K.S. in her progress notes and recorded vital signs. After this initial intake form, there are no other vital signs recorded. Respondent had laboratory tests performed on K.S., including a complete blood count (CBC), urinalysis, chemistry panel, and toxicology screen. All laboratory values were within normal limits, and the toxicology screen was negative, even for benzodiazepines, such as Klonopin, or opiates such as fentanyl. Respondent did not repeat the laboratory tests.

7. On January 5, 2009, K.S. signed her payment agreement and had the program of treatment explained to her, which included live blood cell analysis, “full body” detoxification, Ayurvedic yoga therapy, healthy cooking, meditation, bioresonance sessions, and IV vitamins and chelation as needed. K.S. was provided with some material describing the purposes behind the therapies, general principles and guidelines of Ayurvedic therapies, a healthy cooking food menu, the Ayurvedic toxin-elimination regimen, and live blood evaluation pictorial worksheets. Respondent filled out a history and physical form which
included information about the patient’s current medications, which were fentanyl patch and Klonopin; and her current symptoms, which included excessive sweating, anxiety, severe neck pain, overweight, sleeplessness, and drug withdrawal. No vital signs were recorded on the physical examination portion. This form included a nutritional intake evaluation, where the patient’s usual diet was recorded.

8. Respondent described her mode of medical practice as primarily including a spiritual aspect, where the patient’s mind, body, and spirit are involved. She developed a body constitution questionnaire for this aspect, where the patient assesses his or her general state of mind and body. K.S. filled out this form on January 5, 2009. Respondent believes this aspect of treatment requires connecting and bonding with the patient and that there are no templates for documenting this type of work. On January 5, 2009, K.S. presented respondent with a schedule that the patient wanted to use for tapering off the Klonopin and fentanyl. On that same day, K.S. received a colon cleansing assessment in which a severely impacted bowel was found and colonic irrigation was scheduled. K.S. also received a therapeutic breathing treatment that day and again on January 7 and 9, 2009. Respondent discontinued the stool softener and prescribed Libidex cream and other herbal medications.

9. K.S. enrolled in respondent’s wellness program and not in a pain management program or for assistance with drug withdrawal. Both K.S. and respondent were aware that K.S. was decreasing her drug regimen. Respondent saw her role as supporting the patient’s withdrawal, not directing it. Respondent did not consult with the patient’s pain management physicians or obtain medical records from the patient’s prescribers.

10. K.S. saw respondent on a daily basis during this time. Respondent disimpacted the patient’s bowel and recommended more fiber and warm water intake in addition to herbal remedies.

11. K.S. continued a variety of treatments over a two-week period. K.S. was experiencing nausea, and weakness with fatigue. By January 14, 2009, respondent noted K.S. was tired and dehydrated, and she was given intravenous (IV) vitamin treatment. On January 16, 2009, K.S. reported extreme fatigue, insomnia, and diarrhea. Respondent again administered IV treatment with a vitamin and mineral solution.

12. On January 17, 2009, respondent made a house call because K.S. was too weak to go into the clinic. Respondent recommended fluids and supplements with a slowly advancing vegetable diet, as well as an over-the-counter anti-emetic. Respondent noted that K.S.’s drug dependence/withdrawal was still fluctuating, but with more “better” moments. Respondent documents a “long talk” with K.S. about her past traumas and emotional stressors.

13. Respondent saw K.S. at MDI on January 20, 2009. Respondent notes loss of weight, night sweats, and loss of sleep. She again notes K.S.’s plan to discontinue fentanyl and minimize Klonopin intake. She notes that bowel movements are normal. Respondent’s plan is for diet and lifestyle change, staying on a soft diet, continuing the tapering of drugs, and consulting a chiropractor or physical therapist for pain. Respondent did not refer K.S. to any other physician.
14. K.S. consulted respondent on January 21, 2009. Respondent’s notes indicate that K.S. has reduced the fentanyl patch and that she complains that her whole body aches and she is tired, has constant diarrhea, feels weak, and is dehydrated. Respondent notes drug withdrawal and that the patient seems to be going through personality/behavioral changes. Respondent recommended an herb preparation. Respondent did not refer K.S. to any other physician.

15. On January 25, 2009, K.S. left a voicemail message for respondent reporting her continuing physical distress, and respondent recommended that she see another physician for her physical symptoms. On January 26, 2009, K.S. went to the emergency room at John Muir Hospital and was given IV electrolytes and Zofran with a prescription for Imodium. The emergency room records show that K.S. stated that her symptoms were due to a recent onset of diarrhea, nausea, and vomiting secondary to eating a spinach salad two days earlier.

16. K.S. did not return to her treatment with respondent and sought out an addiction specialist for her drug withdrawal. In February 2009, she was being weaned off of fentanyl and Klonopin with a plan for maintenance treatment with suboxone.

17. K.S.’s complaint to the Board was triggered by a financial dispute. K.S. wanted to use the deposit her mother had at the clinic to pay at least part of K.S.’s bill. Respondent required a written authorization from K.S.’s mother. The one that K.S. supplied was questioned by the staff as a forgery. This made K.S. very angry and was clearly the impetus for the complaint to the board.

18. The Board’s expert, Monica J. Stokes, M.D., states in her C.V. that she is in private practice in integrative medicine, and is a women’s health consultant and author. It was established that she has experience treating patients using Ayurvedic medicine. Her expert testimony concerning respondent’s failure to integrate the Ayurvedic medical modalities with western medical modalities in her treatment of K.S. was persuasive.

19. It was established by clear and convincing evidence through a qualified expert that it was an extreme departure from the standard of practice that respondent failed to consult with K.S.’s other treating practitioners to integrate her alternative treatments with knowledge of concurrent therapies, diagnosis, and assessments by other professionals and coordination of treatment in light of that knowledge.

20. When respondent noted possible mental health diagnoses for K.S., such as bipolar disorder, sleep disorder, anxiety and depression, she documented no basis for these diagnoses, and failed to refer K.S. for mental health treatment, confer with the patient’s other treating physicians, or speak to K.S. about her concerns.

21. Respondent provided no detailed informed consent to K.S. written or documented to show that K.S. fully understood Ayurvedic approaches to treatment. K.S. did not provide informed consent that respondent’s treatment was not intended to treat her physical symptoms or her detoxification process.

22. It was not established by clear and convincing evidence through an expert witness that respondent’s training in Ayurvedic Medicine was inadequate or that her use of Ayurvedic therapies that she employed with K.S. were inappropriate.
23. Respondent’s expert, Dean Nickles, M.D., found that although respondent’s record keeping was below the standard of practice, her treatment of K.S. was within acceptable standards for wellness care. Dr. Nickles practices in Oakland. He opined that it was acceptable to take K.S. as a patient to ease the impact of drug withdrawal. However, he found respondent’s records to be below the standard of practice. He accepted respondent’s claim that she took vital signs after the initial visit. However, he agreed that if she did not take vital signs, it would be an extreme departure from the standard of practice given the complaints of K.S. There was no evidence that respondent actually took vital signs.

*Inaccurate/Inadequate Recordkeeping – Patient K.S.*

24. Respondent stipulated that her record keeping was inadequate. Her notations were sketchy and often illegible. Her progress notes contain very little information besides the patient’s complaints. No vital signs are recorded, except on the initial visit. No assessment is noted. No treatment plan is noted. Respondent provides no detailed description of the modalities employed, the application to the patient, or the basis for the treatment. No components of herbal preparation, or, if prepackaged, the manufacturer, dosage, duration or indication are in the record. Respondent’s records provide very little information concerning the connection between each modality employed, the advice given, the individual condition of the patient, and the outcome sought. Respondent documents no detailed informed consent or that K.S. was given any information concerning conventional treatment or alternatives. It was established by clear and convincing evidence through a qualified expert that respondent’s record keeping taken as a whole (especially the lack of vital signs) was an extreme departure from the standard of practice.

*Gross Negligence/Negligence/Incompetence – Patient J.F.*

25. Patient J.F. first consulted respondent in February 2003, when he and his wife, S.F., were seeking a new primary care physician (PCP), or M.D. internist to act in that capacity, as their previous physician had retired. Respondent was initially consulted by J.F. for an upper respiratory tract infection. In March 2003, respondent referred J.F. to Alta Bates ER for a foot fracture, but did not see him in her office.

26. J.F. next saw respondent on October 21, 2005, at which time he complained of knee pain, hip pain due to osteoarthritis of the left hip, as well as anxiety and stress. He had declined a hip replacement at that time. J.F. also complained of groin pain, which respondent attributed to his hip disease. Respondent ordered supplements, recommended stress management measures (meditation), and ordered x-rays of the hip and knee. The x-rays were followed by MRI’s received in November 2001, which confirmed degenerative changes and other problems.

27. J.F.’s next visit with respondent was on November 1, 2005, at which time he complained of worsening left hip and knee pain and a stressful family situation. Respondent diagnosed hip and knee pain, stress and anxiety, insomnia, and fatigue. Among other things, respondent ordered a complete blood count (CBC) and comprehensive metabolic panel (CMP), as well as PSA alkaline phosphatase and homocysteine levels.
28. On November 3, 2005, J.F. consulted respondent for a “stress evaluation,” and respondent noted that J.F. suffered from chronic pain and insomnia. Respondent noted that no genital or prostate examination was done. Respondent made recommendations. J.F. was seen on November 8, and 11 for hip pain treatments, and on November 11, 2005, respondent entered a diagnosis of hip and knee degenerative joint disease with pain, and she recommended treatments. On November 15, 2005, further knee and hip pain treatments were noted.

29. On November 12, 2005, blood tests were done by the laboratory and reported on November 17, 2005. The results indicated a mildly elevated prostate specific antigen level and a normal alkaline phosphatase level, as well as elevated cholesterol and homocysteine levels. Respondent noted the abnormal labs in the chart when she saw the patient on November 17, 2005, but there is no indication that she discussed the abnormal laboratory findings with J.F., performed a prostate examination or referred J.F. for a prostate examination. No follow-up plan was noted.

30. Respondent’s claim that she discussed the laboratory results with J.F. and suggested a repeat PSA test and referred him to a urologist is not supported in the documentation. J.F. did not follow upon the elevated PSA. J.F.’s final visit with respondent in 2005 was on December 8, 2005. There is no mention in the chart that the elevated PSA test was discussed.

31. In March 2006, J.F. saw respondent after he was in a motor vehicle accident and sustained a back injury. He had several chiropractic treatments for the injury before consulting respondent. J.F. complained mostly about the continuing and worsening of his left hip and knee pain, which was exacerbated by the accident. Respondent recommended massage and acupuncture, and QiGong. Respondent received reports from her referrals. The report of the QiGong expert indicated the patient was complaining of groin pain.

32. By the next visit on May 1, 2006, J.F. reported that he was almost back to normal. Respondent concluded that no more treatments were needed. During June and July 2006, J.F. continued acupuncture treatments and respondent received reports from the acupuncturist.

33. J.F.’s next visit was on July 25, 2006 and it was a follow-up. J.F. reported getting better and respondent recommended continued treatments.

34. The last visit in 2006 was on August 28, 2006, when J.F. complained of eye pain after a trauma. Respondent referred him to an ophthalmologist. Respondent also referred J.F. to an ENT practice for evaluation of a six-month long hearing loss. Respondent received a report that J.F. had a mild hearing loss and recommended a further neurodiagnostic study. There is no notation in the record if this recommendation was followed.

35. J.F. next consulted respondent in February 2007, when he complained of chest wall pain as well as knee and hip pain. Respondent noted his back and right rib/chest pain and attributed it to chondrocondritis with no etiology noted. She recommended work with "Adam." A notation in the margin for this visit indicated “referred to MME Rx-Tucson.” At her physician conference with the Board, respondent denied that she had referred J.F., but
that this was a magnetic treatment for which J.F. had requested a referral to help his joint pain.

36. J.F. had acupuncture and massage for his back, hip, and knee pain on February 26, and March 1, 2007, and the acupuncturist noted left hip and knee pain and also right rib chest pain.

37. J.F. and his wife visited family in Connecticut in May 2007. On May 16, 2007, he consulted a chiropractor there for back pain. The chiropractor did manipulative therapy, and ordered an abdominal ultrasound and lab work that included a PSA level. Lab results indicated a significant elevation in PSA to 182.1 ng/dl, which is way above normal, as well as elevated triglycerides, cholesterol, and an alkaline phosphatase level of 229 U/L which is high and up from his 2005 level. The laboratory sent a copy of the laboratory results to respondent’s clinic. The chiropractor recommended to J.F. that he see a urologist for evaluation immediately upon return to California. J.F. consulted a urologist in Connecticut, who did a digital rectal examination and found suspicious hardening and nodules on the prostate, and recommended a biopsy.

38. J.F. left a message for respondent concerning his high PSA level and his fears of prostate cancer. J.F. and his wife immediately began a search for a formal urological consultation, and made an appointment for evaluation and biopsy at the University of California San Francisco Medical Center (UCSF) five days before J.F.’s June 1, 2007 appointment with respondent. At the June 1, 2007, appointment, J.F. shared the lab results obtained in Connecticut. Respondent noted "awaiting biopsy." She also noted stress and anxiety, abdominal pain and hip DJD. Respondent recommended stress reduction, a CT scan, and biopsy. No laboratory orders are in the chart, and no referrals are noted. There is a copy in the chart of radiology results dated May 27, 2007 ordered by another medical professional. These results indicated a pleural based soft tissue mass along the right lateral mid-chest and recommended a CT scan of the chest.

39. According to respondent’s medical records for J.F., at an appointment on June 4, 2007, the patient completed another stress evaluation and noted that he had urinary or growth problems. Respondent noted chest wall pain; abnormal labs, and left hip pain. She recommended Tylenol and additional neuromuscular rehabilitation treatments. The patient’s last appointment was around June 1, 2007. Follow-up PSA and alkaline phosphatase levels, ordered by respondent were taken on June 26, 2007 and indicated a further elevation of PSA and alkaline phosphatase. A biopsy taken at UCSF on July 5, 2007, indicated Stage IV prostatic adenocarcinoma.

40. It was established by clear and convincing evidence through the testimony of a qualified expert, Dushyant N. Patel, M.D., that respondent’s conduct constitutes gross negligence, repeated negligent acts and incompetence in that as a primary care physician and/or treating physician ordering and receiving laboratory results indicating an abnormal PSA level in November 2005, respondent failed to follow up on the result by explaining and discussing it and other abnormal results with the patient, ordering a repeat test, referring J.F. to a specialist, or doing a digital rectal examination herself. As soon as any physician orders routine laboratory work or screening studies for a patient, she is professionally obligated for the interpretation, evaluation, counseling and follow up care or she must refer the patient to
another physician for appropriate evaluation. She must follow up to check that the patient is following her recommendations. Respondent's treatment of J.F. focused on stress, sleep, and knee/hip pain and her laboratory testing was non-specific, consisting of tests such as biofeedback and dark field microscopy, none of which could provide findings indicating the presence of a major medical illness such as prostate cancer, or provide follow up information on the elevated PSA level.

41. Respondent never followed up on the initial elevated PSA level for her patient, even after he reported groin pain in October 2005, prior to the initial PSA test in November 2005, and groin pain again in April 2006, and groin and chest pain in early 2007. She attributed these symptoms to hip problems and condrochondritis. Groin pain and chest pain can be symptoms of prostate cancer and metastatic disease. Respondent was either ignorant of, or lacked the knowledge or ability to appreciate the importance of follow up on the initial elevated PSA finding for J.F. Respondent missed a number of opportunities to follow up with the elevated PSA. Even after the second PSA level was obtained in Connecticut, she did not document a referral to a urologist, and she did not order a biopsy or any other tests until June 25, 2007.

42. Respondent used both alternative medical therapies and an allopathic medical approach to the patient's care. J.F. was clearly committed to alternative medicine. However, respondent failed to follow up on what needed to be done to diagnose and treat J.F. There was no coherent treatment plan for J.F.

43. The Board's expert, Dushyant N. Patel, M.D., testified concerning the standard of practice for treating a patient with a 5.1 elevated PSA, who is over 50 years old. This situation requires a digital rectal examination to check the prostate. Then the standard of care requires a follow-up PSA. Respondent failed to follow up on J.F.'s complaints of groin pain, and rib pain. Respondent's conduct constitutes an extreme departure from the standard of care because she did not have a treatment plan for the elevated PSA. Vital signs are missing in many of the medical record notes. Respondent's failure to meet the standard of practice led to a delay in J.F. getting the diagnosis and treatment he needed. Respondent's expert, Dean J. Nickles, MD., stated that respondent's record keeping at the time did not include a problem list in the patient chart which would have served as an immediate reminder of any and all future and necessary procedures and tests to be performed for the patient. Dr. Nickles believes this failure created that lack of follow up.

_Inaccurate/Inadequate Recordkeeping – Patient J.F._

44. Respondent claims she was not J.F.'s primary care physician (PCP), but she has no documented verbal or written agreement that made it clear that she did not intend to be his PCP. Even if she did not consider herself his PCP, she apparently did not document an inquiry as to whether he was seeing another physician as PCP, and she never indicated in his records any inquiry as to whether J.F. had followed up with any practitioner concerning the abnormal PSA result of November 2005, and she did not indicate a referral to a urologist or other specialist for follow up. Respondent admits that her record keeping is below the standard of practice and resulted in lack of follow up in this case. Respondent did not adequately or accurately document her care of J.F. The notations concerning J.F. are lacking
in detail and substance. For instance, in May 2006, J.F. received intravenous infusions and there is no clear chart notes that document what was given, the volume infused, over what time frame, how the patient tolerated the procedure or the patient's response to the treatment. Respondent does not identify the practitioner who administered the treatment. Except for an adequate general examination at J.F.'s initial visits in 2003 and 2005, respondent has no consistent record of physical examination findings or vital signs taken and recorded. The records are usually sketchy and often illegible.

Dishonesty

45. With respect to respondent's treatment of J.F., in a deposition taken under oath on February 12, 2009, in a civil case filed against respondent, she indicated that she never discussed prostate health with J.F. because, in her mind, she was not his primary care physician. She indicated that a PSA of 5.1 had to be followed up but not on an emergency basis. However, she did not do any follow up on J.F.'s elevated PSA and did not recall any discussion with J.F. concerning his PSA elevation. She further indicated that she would have sent J.F. to a urologist for follow up if she would have thought of it. As it was, she indicated, the elevated PSA obviously did not get followed up until "things got where they went."

46. On October 13, 2009, when respondent's deposition in the civil case was completed, respondent indicated that she may have discussed urinary function and PSA level with J.F. on November 17, 2005. She did not recall that on any subsequent visit she discussed urinary function or PSA levels. But it was usual for her to discuss these things with her patients, and she may just not have written it down. She had no specific recollections of discussing the 5.1 PSA, or recommending any follow up, but she must have told him to keep an eye on it and to follow up with her on it. She did not follow up between November 2005 and June 2007. She did not refer J.F. to a urologist. She never did a digital rectal examination. In fact, she testified that she does not do them. On February 27, 2007, when J.F. presented with chest wall pain, there was no discussion of abnormal labs or PSA. At the June 1, 2007 visit, respondent recalls J.F. had been seen at UCSF and the he was told to go for a biopsy by an urologist there.

47. On September 15, 2011, respondent had a physician conference with the Board with a medical consultant and a Board investigator. Respondent was represented by counsel at the conference. At that conference, respondent stated that she had detailed discussions with J.F. on November 17, 2005, concerning his abnormal labs, including the PSA results. She pointed out his borderline high PSA and explained his risk factors and the possible reasons for the result, that it could be anything from hypertrophy to cancer or maybe a lab error. She indicated that in one or two months, the PSA level needed to be checked again. She also advised J.F. to go to his "other doctors" for a digital rectal examination, but that she usually referred patients to a urologist. However, J.F. ignored her advice, as he usually ignored anything medical, preferring alternative healers. She did not do any urological examination at the November 17, 2005 visit or check the prostate, as he did not have any urinary symptoms. She reminded J.F. to have the PSA redone and to see a urologist whenever she saw him after that, not just during an appointment. She said J.F. told her he would take care of it but never did. She told J.F. to get the name of a urologist to whom she referred men at the front desk and make an appointment with him, and he was given a lab
slip for a repeat PSA test, but whenever she would check with him, he had not gone to the urologist or gotten the PSA done. Neither the lab slip nor an indication of referral to a urologist is in the patient's medical record. Respondent says that after the high PSA/alkaline prostate readings in Connecticut in mid 2007, J.F. went to a urologist and the urologist recommended a biopsy, but he refused to go, and at the June 1, 2007 appointment, she had to convince him to go for the biopsy. She stated that of the nine or 10 office visits that J.F. had between November 2005 and June 2007, she discussed his prostate and PSA with him a minimum of three or four times. She stated that the 5.1 PSA was borderline, a screening thing, and not an emergency, so she did not want to make it a "big deal."

48. The claimant contends that respondent exhibited dishonesty substantially related to the practice of medicine when she testified inconsistently at her deposition and at her November 2005 physician conference. While there are inconsistencies, these do not rise to the level of dishonesty. Memories can differ and change. Recall can change. What is clear is that respondent's records were not adequate or complete and therefore not helpful in reconstructing what actually was said and done.

49. On April 5, 2013, respondent submitted to the Office of Administrative Hearings a signed declaration under penalty of perjury that she had retained Monica Stokes, M.D. to be her expert on the K.S. case in April 2010 and that she had discussed K.S.'s treatment with her and had discussed her defenses to that case. This was at a time when there was no case pending against respondent concerning her treatment of K.S., but there was an investigation pending and the physician conference with the Board had just taken place. Dr. Stokes was retained to evaluate the K.S. case by the Board more than four months later. Dr. Stokes admits that she spoke to respondent in April 2010, about consulting with her on her integrative medical practices, but denies discussing any specific case or specific Board investigation. Respondent and her counsel requested that Dr. Stokes be disqualified as an expert for the Board. While Dr. Stokes’ discussions give rise to a potential conflict of interest, she was allowed to testify. Although it appears that Dr. Stokes provided an unbiased written opinion, including some findings that were favorable to respondent, she exhibited bias when she testified, changing part of her opinion because she felt her integrity was attacked by the request to have her testimony excluded. While the better practice would have been for Dr. Stokes to recuse herself or for the Board to use a different expert, the use of Dr. Stokes was acceptable.

50. It was not established by clear and convincing evidence that respondent made false or misleading statements or that the statements she made constitute acts of dishonesty substantially related to the practice of medicine.

Other Matters

51. Respondent attended medical school and did her internship in India. After she came to the United States in about 1993, she did an internal medicine residency in Pennsylvania. She presently has a practice in Walnut Creek, California. She lists herself as "Internist/Geriatrician, Holistic Practitioner. She admits her record keeping was below the standard of practice. She attended the Medical Record Keeping Course given by the
University of California, San Diego School of Medicine Continuing Education Program from April 25 -26, 2013.

52. Taking into consideration all the evidence in this matter, this is not simply a case of poor record keeping, as respondent asserts. While it would not be against the public interest to allow respondent to continue to practice medicine, respondent will have the obligation to address the significant shortcomings in her practice, increase her medical knowledge, and improve her understanding of her duties as a physician and surgeon. The specific terms and conditions of probation are designed to protect the public and rehabilitate the respondent and are set forth in the Order below.

LEGAL CONCLUSIONS

1. By reason of the matters set forth in Findings 3 through 23, cause for disciplinary action exists in the case of K.S. pursuant to Business and Professions Code sections 2234, subdivision (b) (gross negligence), (c) repeated acts of negligence), and (d) (incompetence).

2. By reason of the matters set forth in Finding 24, cause for disciplinary action exists in the case of K.S. pursuant to Business and Professions Code section 2266 (failure to maintain adequate and accurate records.)

3. By reason of the matters set forth in Findings 25 through 43, cause for disciplinary action exists in the case of J.F. pursuant to Business and Professions Code sections 2234, subdivision (b) (gross negligence), (c) repeated acts of negligence), and (d) (incompetence).

4. By reason of the matters set forth in Finding 44, cause for disciplinary action exists in the case of J.F. pursuant to Business and Professions Code section 2266 (failure to maintain adequate and accurate records).

5. By reason of the matters set forth in Findings 45 through 50, it was not established by clear and convincing evidence that cause for disciplinary action exists pursuant to Business and Professions Code section 2234, subdivision (e) (dishonesty).

6. The matters set forth in Findings 51 and 52, have been considered in making the following order. This is consistent with Business and Professions Code section 2229, subdivision (b), which requires that disciplinary action should be “calculated to aid in the rehabilitation of the licensee, . . .” as long as the public can be protected. The terms and conditions of probation are designed to insure that respondent is safe to practice in California.

ORDER

Physician and Surgeon’s Certificate No. A 67699 issued to respondent Suprabha Jain, M.D., is revoked. However, revocation is stayed and respondent is placed on probation for 35 months upon the following terms and conditions:
1. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program"). Respondent shall successfully complete the Program not later than six (6) months after respondent’s initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent’s physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent’s area of practice in which respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent’s performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent’s practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. Determination as to whether respondent successfully completed the examination or successfully completed the program is solely within the program’s jurisdiction.

If respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program have been completed. If the respondent did not successfully complete the clinical training program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

2. 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.

3. 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. Respondent’s successful completion of the UC San Diego School of Medicine Medical Record Keeping Course completed on April 26, 2013, meets the requirements of this condition.

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.

4. 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(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), 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 for approval by the Board or its designee.

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.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

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.

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 5 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 receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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.

5. Notification

Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this 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.

6. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.

7. 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.

8. 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.

9. General Probation Requirements

a. Compliance with Probation Unit: Respondent shall comply with the Board’s probation unit and all terms and conditions of this Decision.

b. Address Changes: Respondent shall, at all times, keep the Board informed of respondent’s business and residence addresses, email address (if available), and telephone number. 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(b).

c. Place of Practice: Respondent shall not engage in the practice of medicine in respondent’s or patient’s place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

d. License Renewal: Respondent shall maintain a current and renewed California physician’s and surgeon’s license.

e. Travel or Residence Outside California: 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. 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.

10. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent’s place of business or at the probation unit office, with or without prior notice throughout the term of probation.

11. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent’s return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent’s period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board’s “Manual of Model Disciplinary Orders and Disciplinary Guidelines” prior to resuming the practice of medicine.

Respondent’s period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice 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; and General Probation Requirements.

12. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, 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 or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her license. The Board reserves the right to evaluate respondent’s request and to exercise its discretion in determining 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 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. 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.

This decision shall become effective at 5 p.m. on March 28, 2014.

IT IS SO ORDERED this 27th day of February, 2014.

[Signature]
BARBARA YAROSLAVSKY, CHAIR
PANEL A
MEDICAL BOARD of CALIFORNIA
BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:  )  Case No. 12-2009-197864
)  )
SUPRABHA JAIN, M.D.  )  )  OAH No. 2012070765
)  )
Physician’s & Surgeon’s  )
Certificate No. A 67699  )
)  )
Respondent.  )

ORDER OF NON-ADOPTION
OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been non-adopted. A panel of the Medical Board of California (Board) will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit, including any argument directed to the question of whether the proposed Order sufficiently protects the public. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Diamond Court Reporters, 1107 2nd Street, Suite 210, Sacramento, CA 95814. Their telephone number is (916) 498-9288.

To order a copy of the exhibits, please submit a written request to this Board.

In addition to written argument, oral argument will be scheduled if any party files with the Board within 20 days from the date of this notice a written request for oral argument. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel. The Board directs the parties attention to Title 16 of the California Code of Regulations, sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written argument.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831
(916) 263-6668
Attention: Kelly Montalbano

Dated: November 14, 2013

Barbara Yaroslawsky, Panel A Chair
BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

SUPRABHA JAIN, M.D.,
Physician and Surgeon’s Certificate No.
A 67699

Respondent.

Case No. 12-2009-197864
OAH No. 2012070765

PROPOSED DECISION

Administrative Law Judge Ruth S. Astle, State of California, Office of Administrative
Hearings, heard this matter in Oakland, California on May 13, 14, 15, 16 and June 19 and 20,
2013.

Vivian Hara, Deputy Attorney General, represented complainant.

Respondent Suprabha Jain, M.D., was present and represented by Robert
W. Hodges, Attorney at Law.

Submission of the matter was deferred for receipt of final arguments, which were
received and considered. The matter was submitted on August 21, 2013.

FACTUAL FINDINGS

1. Complainant Kimberly Kirchmeyer made this accusation in her official
capacity as the Interim Executive Director of the Medical Board of California (Board

2. On March 5, 1999, Physician and Surgeon’s Certificate No. A 67699 was
issued by the Board to Suprabha Jain, M.D. (respondent). Respondent’s certificate will
expire March 31, 2015, unless renewed.

Respondent has not been the subject of prior disciplinary action.
Gross Negligence/Negligence/Incompetence - Patient K.S.

3. K.S. first consulted respondent at Mt. Diablo Wellness Center, Inc. (MDI) on January 4, 2009. K.S. had issues with anxiety, depression, and pain since she was 28 years old. She had consulted an acupuncturist and a chiropractor. She was also a patient of an integrative pain management clinic in Concord, California. Respondent was never K.S.’s primary care physician. K.S. suffered from chronic neck and low back pain; her weight was 210 pounds at the time she first consulted respondent. She also complained of always being cold and sleeping 14 hours a day. She indicated on her MDI patient information sheet that her reason for consulting respondent was “sweats and muscle spasm.”

4. K.S. reported that in the previous year, she had decided to reduce or eliminate a number of drugs she was taking for her medical conditions. Her prescribed drugs included Advair, albuterol, Xanax, Dilaudid, Oxycodone, Effexor, Abilify, Klonopin, fentanyl patches, and a stool softener. She had been reducing or eliminating the drugs by herself without medical supervision. She stopped using all prescribed medications except Klonopin and fentanyl patches at the time she consulted respondent.

5. When K.S. began suffering from sweats and nausea, her son recommended respondent’s clinic. K.S.’s mother had been respondent’s patient previously and had $5,000 in unapplied deposits reserved at MDI. K.S. called MDI and was able to make an appointment with respondent for the next day, January 4, 2009. K.S. filled out a patient information sheet and was examined by respondent. Respondent recognized that K.S. was suffering the effects of narcotics/controlled substance withdrawal.

6. Respondent developed a “medical model” form for intake history and physical. On January 4, 2009, K.S. filled out the first page of a patient information form; the second page was left blank. Respondent recorded a brief medical history of K.S. in her progress notes and recorded vital signs. After this initial intake form, there are no other vital signs recorded. Respondent had laboratory tests performed on K.S., including a complete blood count (CBC), urinalysis, chemistry panel, and toxicology screen. All laboratory values were within normal limits, and the toxicology screen was negative, even for benzodiazepines, such as Klonopin, or opiates such as fentanyl. Respondent did not repeat the laboratory tests.

7. On January 5, 2009, K.S. signed her payment agreement and had the program of treatment explained to her, which included live blood cell analysis, “full body” detoxification, Ayurvedic yoga therapy, healthy cooking, meditation, bioresonance sessions, and IV vitamins and chelation as needed. K.S. was provided with some material describing the purposes behind the therapies, general principles and guidelines of Ayurvedic therapies, a healthy cooking food menu, the Ayurvedic toxin-elimination regimen, and live blood evaluation pictorial worksheets. Respondent filled out a history and physical form which included information about the patient’s current medications, which were fentanyl patch and Klonopin; and her current symptoms, which included excessive sweating, anxiety, severe neck pain, overweight, sleeplessness, and drug withdrawal. No vital signs were recorded on
the physical examination portion. This form included a nutritional intake evaluation, where
the patient’s usual diet was recorded.

8. Respondent described her mode of medical practice as primarily including a
spiritual aspect, where the patient’s mind, body, and spirit are involved. She developed a
body constitution questionnaire for this aspect, where the patient assesses his or her general
state of mind and body. K.S. filled out this form on January 5, 2009. Respondent believes
this aspect of treatment requires connecting and bonding with the patient and that there are
no templates for documenting this type of work. On January 5, 2009, K.S. presented
respondent with a schedule that the patient wanted to use for tapering off the Klonopin and
fentanyl. On that same day, K.S. received a colon cleansing assessment in which a severely
impacted bowel was found and colonic irrigation was scheduled. K.S. also received a
therapeutic breathing treatment that day and again on January 7 and 9, 2009. Respondent
discontinued the stool softener and prescribed Libidex cream and other herbal medications.

9. K.S. enrolled in respondent’s wellness program and not in a pain management
program or for assistance with drug withdrawal. Both K.S. and respondent were aware that
K.S. was decreasing her drug regimen. Respondent saw her role as supporting the patient’s
withdraw, not directing it. Respondent did not consult with the patient’s pain management
physicians or obtain medical records from the patient’s prescribers.

10. K.S. saw respondent on a daily basis during this time. Respondent
disimpacted the patient’s bowel and recommended more fiber and warm water intake in
addition to herbal remedies.

11. K.S. continued a variety of treatments over a two-week period. K.S. was
experiencing nausea, and weakness with fatigue. By January 14, 2009, respondent noted
K.S. was tired and dehydrated, and she was given intravenous (IV) vitamin treatment. On
January 16, 2009, K.S. reported extreme fatigue, insomnia, and diarrhea. Respondent again
administered IV treatment with a vitamin and mineral solution.

12. On January 17, 2009, respondent made a house call because K.S. was too
weak to go into the clinic. Respondent recommended fluids and supplements with a slowly
advancing vegetable diet, as well as an over-the-counter anti-emetic. Respondent noted that
K.S.’s drug dependence/withdrawal was still fluctuating, but with more “better” moments.
Respondent documents a “long talk” with K.S. about her past traumas and emotional
stressors.

weight, night sweats, and loss of sleep. She again notes K.S.’s plan to discontinue fentanyl
and minimize Klonopin intake. She notes that bowel movements are normal. Respondent’s
plan is for diet and lifestyle change, staying on a soft diet, continuing the tapering of drugs,
and consulting a chiropractor or physical therapist for pain. Respondent did not refer K.S. to
any other physician.
14. K.S. consulted respondent on January 21, 2009. Respondent’s notes indicate that K.S. has reduced the fentanyl patch and that she complains that her whole body aches and she is tired, has constant diarrhea, feels weak, and is dehydrated. Respondent notes drug withdrawal and that the patient seems to be going through personality/behavioral changes. Respondent recommended an herb preparation. Respondent did not refer K.S. to any other physician.

15. On January 25, 2009, K.S. left a voicemail message for respondent reporting her continuing physical distress, and respondent recommended that she see another physician for her physical symptoms. On January 26, 2009, K.S. went to the emergency room at John Muir Hospital and was given IV electrolytes and Zofran with a prescription for Imodium. The emergency room records show that K.S. stated that her symptoms were due to a recent onset of diarrhea, nausea, and vomiting secondary to eating a spinach salad two days earlier.

16. K.S. did not return to her treatment with respondent and sought out an addiction specialist for her drug withdrawal. In February 2009, she was being weaned off of fentanyl and Klonopin with a plan for maintenance treatment with suboxone.

17. It was established by clear and convincing evidence through a qualified expert that it was an extreme departure from the standard of practice that respondent failed to consult with K.S.’s other treating practitioners to integrate her alternative treatments with knowledge of concurrent therapies, diagnosis, and assessments by other professionals and coordination of treatment in light of that knowledge.

18. Respondent provided no detailed informed consent to K.S., written or documented to show that K.S. fully understood Ayurvedic approaches to treatment. K.S. did not provide informed consent that respondent’s treatment was not intended to treat her physical symptoms or her detoxification process.

19. When respondent noted possible mental health diagnoses for K.S., such as bipolar disorder, sleep disorder, anxiety and depression, she documented no basis for these diagnoses, and failed to refer K.S. for mental health treatment, confer with the patient’s other treating physicians, or speak to K.S. about her concerns.

20. It was not established by clear and convincing evidence through an expert witness that respondent’s training in Ayurvedic Medicine was inadequate or that her use of Ayurvedic therapies that she employed with K.S. were inappropriate.

21. K.S.’s complaint to the board was triggered by a financial dispute. K.S. wanted to use the deposit her mother had at the clinic to pay at least part of K.S.’s bill. Respondent required a written authorization from K.S.’s mother. The one that K.S. supplied was questioned by the staff as a forgery. This made K.S. very angry and was clearly the impetus for the complaint to the board.
22. The Board's expert, Monica J. Stokes, M.D., states in her C.V. that she is in private practice in integrative medicine, and is a women's health consultant and author. It was not established that she ever treated any patients using Ayurvedic medicine. Her criticisms of respondent in that regard were not persuasive. However, her expert testimony concerning respondent's failure to integrate the Ayurvedic medical modalities with western medical modalities was persuasive.

23. Respondent's expert, Dean Nickles, M.D., found that although respondent's record keeping was below the standard of practice, her treatment of K.S. was within acceptable standards for wellness care. Dr. Nickles practices in Oakland. He opined that it was acceptable to take K.S. as a patient to ease the impact of drug withdrawal. However, he found respondent's records to be below the standard of practice. He accepted respondent's claim that she took vital signs after the initial visit. However, he agreed that if she did not take vital signs, it would be an extreme departure from the standard of practice given the complaints of K.S. There was no evidence that respondent actually took vital signs.

Inaccurate/Inadequate Recordkeeping – Patient K.S.

24. Respondent stipulated that her record keeping was inadequate. Her notations were sketchy and often illegible. Her progress notes contain very little information besides the patient's complaints. No vital signs are recorded, except on the initial visit. No assessment is noted. No treatment plan is noted. Respondent provides no detailed description of the modalities employed, the application to the patient, or the basis for the treatment. No components of herbal preparation, or, if prepackaged, the manufacturer, dosage, duration or indication are in the record. Respondent's records provide very little information concerning the connection between each modality employed, the advice given, the individual condition of the patient, and the outcome sought. Respondent documents no detailed informed consent or that K.S. was given any information concerning conventional treatment or alternatives. It was established by clear and convincing evidence through a qualified expert that respondent's record keeping taken as a whole (especially the lack of vital signs) was an extreme departure from the standard of practice.

Gross Negligence/Negligence/Incompetence – Patient J.F.

25. Patient J.F. first consulted respondent in February 2003, when he and his wife, S.F., were seeking a new primary care physician (PCP), or M.D. internist to act in that capacity, as their previous physician had retired. Respondent was initially consulted by J.F. for an upper respiratory tract infection. In March 2003, respondent referred J.F. to Alta Bates ER for a foot fracture, but did not see him in her office.

26. J.F. next saw respondent on October 21, 2005, at which time he complained of knee pain, hip pain due to osteoarthritis of the left hip, as well as anxiety and stress. He had declined a hip replacement at that time. J.F. also complained of groin pain, which respondent attributed to his hip disease. Respondent ordered supplements, recommended stress management measures (meditation), and ordered x-rays of the hip and knee. The x-
rays were followed by MRI’s received in November 2001, which confirmed degenerative changes and other problems.

27. J.F.’s next visit with respondent was on November 1, 2005, at which time he complained of worsening left hip and knee pain and a stressful family situation. Respondent diagnosed hip and knee pain, stress and anxiety, insomnia, and fatigue. Among other things, respondent ordered a complete blood count (CBC) and comprehensive metabolic panel (CMP), as well as PSA alkaline phosphatase and homocysteine levels.

28. On November 3, 2005, J.F. consulted respondent for a “stress evaluation,” and respondent noted that J.F. suffered from chronic pain and insomnia. Respondent noted that no genital or prostate examination was done. Respondent made recommendations. J.F. was seen on November 8, and 11 for hip pain treatments, and on November 11, 2005, respondent entered a diagnosis of hip and knee degenerative joint disease with pain, and she recommended treatments. On November 15, 2005, further knee and hip pain treatments were noted.

29. On November 12, 2005, blood tests were done by the laboratory and reported on November 17, 2005. The results indicated a mildly elevated prostate specific antigen level and a normal alkaline phosphatase level, as well as elevated cholesterol and homocysteine levels. Respondent noted the abnormal labs in the chart when she saw the patient on November 17, 2005, but there is no indication that she discussed the abnormal laboratory findings with J.F., performed a prostate examination or referred J.F. for a prostate examination. No follow-up plan was noted.

30. Respondent’s claim that she discussed the laboratory results with J.F. and suggested a repeat PSA test and referred him to a urologist is not supported in the documentation. J.F. did not follow upon the elevated PSA. J.F.’s final visit with respondent in 2005 was on December 8, 2005. There is no mention in the chart that the elevated PSA test was discussed.

31. In March 2006, J.F. saw respondent after he was in a motor vehicle accident and sustained a back injury. He had several chiropractic treatments for the injury before consulting respondent. J.F. complained mostly about the continuing and worsening of his left hip and knee pain, which was exacerbated by the accident. Respondent recommended massage and acupuncture, and QiGong. Respondent received reports from her referrals. The report of the QiGong expert indicated the patient was complaining of groin pain.

32. By the next visit on May 1, 2006, J.F. reported that he was almost back to normal. Respondent concluded that no more treatments were needed. During June and July 2006, J.F. continued acupuncture treatments and respondent received reports from the acupuncturist.

33. J.F.’s next visit was on July 25, 2006 and it was a follow-up. J.F. reported getting better and respondent recommended continued treatments.
35. The last visit in 2006 was on August 28, 2006, when J.F. complained of eye pain after a trauma. Respondent referred him to an ophthalmologist. Respondent also referred J.F. to an ENT practice for evaluation of a six-month long hearing loss. Respondent received a report that J.F. had a mild hearing loss and recommended a further neurodiagnostic study. There is no notation in the record if this recommendation was followed.

36. J.F. next consulted respondent in February 2007, when he complained of chest wall pain as well as knee and hip pain. Respondent noted his back and right rib/chest pain and attributed it to chondrocondritis with no etiology noted. She recommended work with "Adam." A notation in the margin for this visit indicated "referred to MME Rx-Tucson." At her physician conference with the Board, respondent denied that she had referred J.F., but that this was a magnetic treatment for which J.F. had requested a referral to help his joint pain.

37. J.F. had acupuncture and massage for his back, hip, and knee pain on February 26, and March 1, 2007, and the acupuncturist noted left hip and knee pain and also right rib chest pain.

38. J.F. and his wife visited family in Connecticut in May 2007. On May 16, 2007, he consulted a chiropractor there for back pain. The chiropractor did manipulative therapy, and ordered an abdominal ultrasound and lab work that included a PSA level. Lab results indicated a significant elevation in PSA to 182.1 ng/ml, which is way above normal, as well as elevated triglycerides, cholesterol, and an alkaline phosphatase level of 229 U/L which is high and up from his 2005 level. The laboratory sent a copy of the laboratory results to respondent's clinic. The chiropractor recommended to J.F. that he see a urologist for evaluation immediately upon return to California. J.F. consulted a urologist in Connecticut, who did a digital rectal examination and found suspicious hardening and nodules on the prostate, and recommended a biopsy.

39. J.F. left a message for respondent concerning his high PSA level and his fears of prostate cancer. J.F and his wife immediately began a search for a formal urological consultation, and made an appointment for evaluation and biopsy at the University of California San Francisco Medical Center (UCSF) five days before J.F.'s June 1, 2007 appointment with respondent. At the June 1, 2007, appointment, J.F. shared the lab results obtained in Connecticut. Respondent noted "awaiting biopsy." She also noted stress and anxiety, abdominal pain and hip DJD. Respondent recommended stress reduction, a CT scan, and biopsy. No laboratory orders are in the chart, and no referrals are noted. There is a copy in the chart of radiology results dated May 27, 2007 ordered by another medical professional. These results indicated a pleural based soft tissue mass along the right lateral mid-chest and recommended a CT scan of the chest.

40. According to respondent's medical records for J.F., at an appointment on June 4, 2007, the patient completed another stress evaluation and noted that he had urinary or
growth problems. Respondent noted chest wall pain; abnormal labs, and left hip pain. She recommended Tylenol and additional neuromuscular rehabilitation treatments. The patient's last appointment was around June 1, 2007. Follow-up PSA and alkaline phosphatase levels, ordered by respondent were taken on June 26, 2007 and indicated a further elevation of PSA and alkaline phosphatase. A biopsy taken at UCSF on July 5, 2007, indicated Stage IV prostatic adenocarcinoma.

41. It was established by clear and convincing evidence through the testimony of a qualified expert, Dushyant N. Patel, M.D., that respondent's conduct constitutes gross negligence, repeated negligent acts and incompetence in that as a primary care physician and/or treating physician ordering and receiving laboratory results indicating an abnormal PSA level in November 2005, respondent failed to follow up on the result by explaining and discussing it and other abnormal results with the patient, ordering a repeat test, referring J.F. to a specialist, or doing a digital rectal examination herself. As soon as any physician orders routine laboratory work or screening studies for a patient, she is professionally obligated for the interpretation, evaluation, counseling and follow up care or she must refer the patient to another physician for appropriate evaluation. She must follow up to check that the patient is following her recommendations. Respondent's treatment of J.F. focused on stress, sleep, and knee/hip pain and her laboratory testing was non-specific, consisting of tests such as biofeedback and dark field microscopy, none of which could provide findings indicating the presence of a major medical illness such as prostate cancer, or provide follow up information on the elevated PSA level.

42. Respondent never followed up on the initial elevated PSA level for her patient, even after he reported groin pain in October 2005, prior to the initial PSA test in November 2005, and groin pain again in April 2006, and groin and chest pain in early 2007. She attributed these symptoms to hip problems and condrochondritis. Groin pain and chest pain can be symptoms of prostate cancer and metastatic disease. Respondent was either ignorant of, or lacked the knowledge or ability to appreciate the importance of follow up on the initial elevated PSA finding for J.F. Respondent missed a number of opportunities to follow up with the elevated PSA. Even after the second PSA level was obtained in Connecticut, she did not document a referral to a urologist, and she did not order a biopsy or any other tests until June 25, 2007.

43. Respondent used both alternative medical therapies and an allopathic medical approach to the patient's care. J.F. was clearly committed to alternative medicine. However, respondent failed to follow up on what needed to be done to diagnose and treat J.F. There was no coherent treatment plan for J.F.

44. The Board’s expert, Dushyant N. Patel, M.D., testified concerning the standard of practice for treating a patient with a 5.1 elevated PSA, who is over 50 years old. This situation requires a digital rectal examination to check the prostate. Then the standard of care requires a follow-up PSA. Respondent failed to follow up on J.F.’s complaints of groin pain, and rib pain. Respondent's conduct constitutes an extreme departure from the standard of care because she did not have a treatment plan for the elevated PSA. Vital signs are
missing in many of the medical record notes. Respondent's failure to meet the standard of practice led to a delay in J.F. getting the diagnosis and treatment he needed. Respondent's expert, Dean J. Nickles, MD., stated that respondent's record keeping at the time did not include a problem list in the patient chart which would have served as an immediate reminder of any and all future and necessary procedures and tests to be performed for the patient. Dr. Nickles believes this failure created that lack of follow up.

Inaccurate/Inadequate Recordkeeping – Patient J.F.

45. Respondent claims she was not J.F.'s primary care physician (PCP), but she has no documented verbal or written agreement that made it clear that she did not intend to be his PCP. Even if she did not consider herself his PCP, she apparently did not document an inquiry as to whether he was seeing another physician as PCP, and she never indicated in his records any inquiry as to whether J.F. had followed up with any practitioner concerning the abnormal PSA result of November 2005, and she did not indicate a referral to a urologist or other specialist for follow up. Respondent admits that her record keeping is below the standard of practice and resulted in lack of follow up in this case. Respondent did not adequately or accurately document her care of J.F. The notations concerning J.F. are lacking in detail and substance. For instance, in May 2006, J.F. received intravenous infusions and there is no clear chart notes that document what was given, the volume infused, over what time frame, how the patient tolerated the procedure or the patient's response to the treatment. Respondent does no identify the practitioner who administered the treatment. Except for an adequate general examination at J.F.'s initial visits in 2003 and 2005, respondent has not consistent record of physical examination findings or vital signs taken and recorded. The records are usually sketchy and often illegible.

Dishonesty

46. With respect to respondent's treatment of J.F., in a deposition taken under oath on February 12, 2009, in a civil case filed against respondent, she indicated that she never discussed prostate health with J.F. because, in her mind, she was not his primary care physician. She indicated that a PSA of 5.1 had to be followed up but not on an emergency basis. However, she did not do any follow up on J.F.'s elevated PSA and did not recall any discussion with J.F. concerning his PSA elevation. She further indicated that she would have sent J.F. to a urologist for follow up if she would have thought of it. As it was, she indicated, the elevated PSA obviously did not get followed up until "things got where they went."

47. On October 13, 2009, when respondent's deposition in the civil case was completed, respondent indicated that she may have discussed urinary function and PSA level with J.F. on November 17, 2005. She did not recall that on any subsequent visit she discussed urinary function or PSA levels. But it was usual for her to discuss these things with her patients, and she may just not have written it down. She had no specific recollections of discussing the 5.1 PSA, or recommending any follow up, but she must have told him to keep an eye on it and to follow up with her on it. She did not follow up between November 2005 and June 2007. She did not refer J.F. to a urologist. She never did a digital
rectal examination. In fact, she testified that she does not do them. On February 27, 2007, when J.F. presented with chest wall pain, there was no discussion of abnormal labs or PSA. At the June 1, 2007 visit, respondent recalls J.F. had been seen at UCSF and the he was told to go for a biopsy by an urologist there.

48. On September 15, 2011, respondent had a physician conference with the Board with a medical consultant and a Board investigator. Respondent was represented by counsel at the conference. At that conference, respondent stated that she had detailed discussions with J.F. on November 17, 2005, concerning his abnormal labs, including the PSA results. She pointed out his borderline high PSA and explained his risk factors and the possible reasons for the result, that it could be anything from hypertrophy to cancer or maybe a lab error. She indicated that in one or two months, the PSA level needed to be checked again. She also advised J.F. to go to his "other doctors" for a digital rectal examination, but that she usually referred patients to a urologist. However, J.F. ignored her advice, as he usually ignored anything medical, preferring alternative healers. She did not do any urological examination at the November 17, 2005 visit or check the prostate, as he did not have any urinary symptoms. She reminded J.F. to have the PSA redone and to see a urologist whenever she saw him after that, not just during an appointment. She said J.F. told her he would take care of it but never did. She told J.F. to get the name of a urologist to whom she referred men at the front desk and make an appointment with him, and he was given a lab slip for a repeat PSA test, but whenever she would check with him, he had not gone to the urologist or gotten the PSA done. Neither the lab slip nor an indication of referral to a urologist is in the patient’s medical record. Respondent says that after the high PSA/alkaline prostate readings in Connecticut in mid 2007, J.F. went to a urologist and the urologist recommended a biopsy, but he refused to go, and at the June 1, 2007 appointment, she had to convince him to go for the biopsy. She stated that of the nine or 10 office visits that J.F. had between November 2005 and June 2007, she discussed his prostate and PSA with him a minimum of three or four times. She stated that the 5.1 PSA was borderline, a screening thing, and not an emergency, so she did not want to make it a "big deal."

49. The Board contends that respondent exhibited dishonesty substantially related to the practice of medicine when she testified inconsistently at her deposition and at her November 2005 physician conference. While there are inconsistencies, these do not rise to the level of dishonesty. Memories can differ and change. Recall can change. What is clear is that respondent's records were not adequate or complete and therefore not helpful in reconstructing what actually was said and done.

50. On April 5, 2013, respondent submitted to the Office of Administrative Hearings a signed declaration under penalty of perjury that she had retained Monica Stokes, M.D. to be her expert on the K.S. case in April 2010 and that she had discussed K.S.'s treatment with her and had discussed her defenses to that case. This was at a time when there was no case pending against respondent concerning her treatment of K.S., but there was an investigation pending and the physician conference with the Board had just taken place. Dr. Stokes was retained to evaluate the K.S. case by the Board more than four months later. Dr. Stokes admits that she spoke to respondent in April 2010, about consulting with her on
her integrative medical practices, but denies discussing any specific case or specific Board investigation. Respondent and her counsel requested that Dr. Stokes be disqualified as an expert for the Board. While Dr. Stokes discussions give rise to a potential conflict of interest, she was allowed to testify. Although it appears that Dr. Stokes provided an unbiased written opinion, including some findings that were favorable to respondent, she exhibited bias when she testified, changing part of her opinion because she felt her integrity was attacked by the request to have her testimony excluded. While the better practice would have been for Dr. Stokes to recuse herself or for the Board to use a different expert, the use of Dr. Stokes was acceptable.

51. It was not established by clear and convincing evidence that respondent made false or misleading statements or that the statements she made constitute acts of dishonesty substantially related to the practice of medicine.

Other Matters

52. Respondent attended medical school and did her internship in India. After she came to the United States in about 1993, she did an internal medicine residency in Pennsylvania. She presently has a practice in Walnut Creek, California. She lists herself as "Internist/Geriatrician, Holistic Practitioner. She admits her record keeping was below the standard of practice. She attended the Medical Record Keeping Course given by the University of California, San Diego School of Medicine Continuing Education Program from April 25 - 26, 2013.

53. Taking into consideration all the evidence in this matter, it would not be against the public interest to allow respondent to continue to practice medicine under specific terms and conditions of probation as set forth below.

LEGAL CONCLUSIONS

1. By reason of the matters set forth in Findings 3 through 23, cause for disciplinary action exists in the case of K.S. pursuant to Business and Professions Code sections 2234, subdivision (b) (gross negligence), (c) repeated acts of negligence), and (d) (incompetence).

2. By reason of the matters set forth in Finding 24, cause for disciplinary action exists in the case of K.S. pursuant to Business and Professions Code section 2266 (failure to maintain adequate and accurate records.)

3. By reason of the matters set forth in Findings 25 through 44, cause for disciplinary action exists in the case of J.F. pursuant to Business and Professions Code sections 2234, subdivision (b) (gross negligence), (c) repeated acts of negligence), and (d) (incompetence).
4. By reason of the matters set forth in Finding 45, cause for disciplinary action
exists in the case of J.F. pursuant to Business and Professions Code section 2266 (failure to
maintain adequate and accurate records).

5. By reason of the matters set forth in Findings 46 through 51, it was not
established by clear and convincing evidence that cause for disciplinary action exists
pursuant to Business and Professions Code section 2234, subdivision (e) (dishonesty).

6. The matters set forth in Findings 52 and 53, have been considered in making
the following order. This is consistent with Business and Professions Code section 2229,
subdivision (b), which requires that disciplinary action should be “calculated to aid in the
rehabilitation of the licensee, . . .” as long as the public can be protected. The terms and
conditions of probation are designed to insure that respondent is safe to practice in
California.

ORDER

Physician and Surgeon’s Certificate No. A 67699 issued to respondent Suprabha Jain,
M.D., is revoked. However, revocation is stayed and respondent is placed on probation for
three (3) 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 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. Respondent’s successful completion of the UC San
Diego School of Medicine Medical Record Keeping Course completed on April 26, 2013,
meets the requirements of this condition.
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 Division 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 Division, 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 Division or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), 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 Division or its designee which includes an evaluation of respondent’s performance, indicating whether respondent’s practices are within the standards of practice of medicine or billing, or both, 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 Division 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 5 calendar
days of such resignation or unavailability, submit to the Division 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 3 calendar days after being so notified by the Division
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 the respondent shall provide a true copy
of the Decision(s) and Accusation(s) 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. 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.
6. 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.

7. 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 license.

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 30 calendar days.

8. 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.

9. 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 thirty 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 and Probation Unit Compliance.

Respondent’s license shall be automatically cancelled if respondent’s periods of temporary or permanent residence or practice outside California totals two years. However, respondent’s license 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.

Any respondent disciplined under B&P Code sections 141(a) or 2305 (another state discipline) may petition for modification or termination of penalty: 1) if the other state’s discipline terms are modified, terminated or reduced; and 2) if at least one year has elapsed from the effective date of the California discipline.

10. 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 thirty 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 license 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.

11. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, 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.
12. 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.

13. 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 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.

14. 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: September 20, 2013

[Signature]
RUTH S. ASTLE
Administrative Law Judge
Office of Administrative Hearings