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

In the Matter of the Accusation Against:	)	
JOSE ALFREDO MARTINEZ, M.D.	)	File No. 06-2002-135540
Physician's and Surgeon's Certificate No. G - 49769	)	
Respondent	)	

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on December 1, 2005.

IT IS SO ORDERED December 21, 2005.

MEDICAL BOARD OF CALIFORNIA

By: _____
Ronald L. Moy, M.D., Chair
Panel B
Division of Medical Quality

BILL LOCKYER, Attorney General
of the State of California
JOHN E. DeCURE, State Bar No. 150700
Deputy Attorney General
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-8854
Facsimile: (213) 897-9395

Attorneys for Complainant

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

In the Matter of the Accusation Against: JOSE ALFREDO MARTINEZ, M.D. Pacific Olive Medical Group 7723 Pacific Boulevard Huntington Park, California 90255 Physician's and Surgeon's Certificate No. G 49769 Respondent.	Case No. 06-2002-135540 OAH No. l-2004070686 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties in this proceeding that the following matters are true:

PARTIES

1. David T. Thornton (Complainant) is the Executive Director of the Medical Board of California. Mr. Thornton brought this action solely in his official capacity and is represented in this matter by Bill Lockyer, Attorney General of the State of California, by John E. DeCure, Deputy Attorney General.

2. Jose Alfredo Martinez, M.D. (Respondent) is represented in this proceeding by attorney Ralph Larsen, whose address is 1638 East 17th Street, Suite G Santa Ana, CA 92705.

3. On or about April 11, 1983, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. G 49769 to Jose Alfredo Martinez, M.D. (Respondent). The Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 06-2002-135540 and will expire on July 31, 2004, unless renewed.

JURISDICTION

4. Accusation No. 06-2002-135540 was filed before the Board and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on June 3, 2004. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 06-2002-135540 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 06-2002-135540. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 06-2002-135540, agrees that cause exists for discipline and hereby surrenders his Physician's and Surgeon's Certificate No. G 49769 for the Board's formal acceptance.

9. Respondent understands that by signing this stipulation he enables the Board to make an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

10. The parties understand and agree that facsimile copies of this Stipulated Surrender of License and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

11. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 49769, issued to Respondent Jose Alfredo Martinez, M.D. is surrendered and accepted by the Medical Board of California.

12. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

13. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order. This surrender will be effective as of December 1, 2005.

14. Respondent shall cause to be delivered to the Board both his Certificate wall and pocket license certificate on or before the effective date of the Decision and Order.

15. Respondent fully understands and agrees that if he ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent may apply for reinstatement within two years from the effective date of this decision. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all

of the charges and allegations contained in Accusation No. 06-2002-135540 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Ralph Larsen. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11/7/05.

Jose Alfredo Martinez, M.D.
Respondent

I have read and fully discussed with Respondent Jose Alfredo Martinez, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 11/07/05.

RALPH LARSEN
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: Nov. 22, 2005.

BILL LOCKYER, Attorney General
of the State of California

JOHN E. DeCURE
Deputy Attorney General

Attorneys for Complainant

DOJ Matter ID: LA2004600715
60097582.wpd

Exhibit A

Accusation No. 06-2002-135540

BILL LOCKYER, Attorney General
of the State of California
NANCY A. STONER, State Bar No. 72839
Deputy Attorney General, for
ROBERT EISMAN
Deputy Attorney General
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2575
Facsimile: (213) 897-9395

Attorneys for Complainant

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

In the Matter of the Accusation Against: JOSE ALFREDO MARTINEZ, M.D. 7723 Pacific Blvd. Huntington Park, California 90255 Physician and Surgeon's Certificate No. G 49769 Respondent.	Case No. 06-2002-135540 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. David T. Thornton (Complainant) brings this Accusation solely in his official capacity as the Interim Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

2. On or about April 11, 1983, the Board issued Physician and Surgeon's Certificate No. G 49769 to Jose Alfredo Martinez, M.D. (Respondent). The Physician and Surgeon's Certificate was in effect at all times relevant to the charges brought herein and will expire on July 31, 2004, unless renewed.

On or about March 7, 2004, Respondent's Physician and Surgeon's Certificate

was suspended pursuant to Family Code section 17520, for failure to pay child support. The suspension was terminated on or about March 29, 2004, upon notification from the Child Support Services Department that Respondent was in compliance with the judgment or order for support.

On or about February 20, 1985, Respondent obtained from the Board a fictitious name permit to practice medicine under the name Pacific Olive Medical Clinic, FNP No. 10942. The fictitious name permit was canceled on March 5, 2000 for non-payment of renewal fees.

JURISDICTION

3. This Accusation is brought before the Board's Division of Medical Quality (Division) under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the division, may, in accordance with the provisions of this chapter:

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

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

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

"(4) Be publicly reprimanded by the division.

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

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the division and successfully completed by the licensee, or other matters made confidential or

privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2234 of the Code states:

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

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts.[1]

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

6. Section 119 of the Code states, in pertinent part:

"Any person who does any of the following is guilty of a misdemeanor:

"(a) Displays or causes or permits to be displayed or has in his or her possession

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1. Respondent's acts and omissions occurred prior to the January 1, 2003, effective date of the amended definition of repeated negligent acts in Business and Professions Code section 2234, subdivision (c) which now states:

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

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

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

either of the following:

"(1) A canceled, revoked, suspended, or fraudulently altered license.

"(2) A fictitious license or any document simulating a license or purporting to be or have been issued as a license.

"(b) Lends his or her license to any other person or knowingly permits the use thereof by another.

". . . .

"(e) Knowingly permits any unlawful use of a license issued to him or her.

"(f) Photographs, photostats, duplicates, manufactures, or in any way reproduces any license or facsimile thereof in a manner that it could be mistaken for a valid license, or displays or has in his or her possession any such photograph, photostat, duplicate, reproduction, or facsimile unless authorized by this code."

7. Section 651 of the Code states:

"(a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated, any form of public communication containing a false, fraudulent, misleading, or deceptive statement or claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. A 'public communication' as used in this section includes, but is not limited to, communication by means of mail, television, radio, motion picture, newspaper, book, list or directory of healing arts practitioners. Internet or other electronic communication.

"(b) A false, fraudulent, misleading, or deceptive statement, claim or image includes a statement or claim that does any of the following:

"(1) Contains a misrepresentation of fact.

"(2) Is likely to mislead or deceive because of a failure to disclose material facts.

"(3) Is intended or is likely to create false or unjustified expectations of favorable results.

". . . .

(5) Contains other representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived.

". . . .

"(e) Any person so licensed may not use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive within the meaning of subdivision (b).

". . . .

"(g) Any violation of any provision of this section by a person so licensed shall constitute good cause for revocation or suspension of his or her license or other disciplinary action."

8. Section 652 of the Code states, in pertinent part:

"Violation of this article [Article 6, commencing with Section 650 of the Code] in the case of a licensed person constitutes unprofessional conduct and grounds for suspension or revocation of his or her license by the board by whom he or she is licensed."

9. Section 2021 of the Code states, in pertinent part:

"(a) If the board publishes a directory pursuant to Section 112, it may require persons licensed pursuant to this chapter [Chapter 5, the Medical Practice Act] to furnish any information as it may deem necessary to enable it to compile the directory.

"(b) Each licensee shall report to the board each and every change of address within 30 days after each change, giving both the old and new address. If an address reported to the board at the time of application for licensure or subsequently is a post office box, the applicant shall also provide the board with a street address. If the another address is the licensee's address of record, he or she may request that the second address not be disclosed to the public.

"(c) Each licensee shall report to the board each and every change of name within 30 days after each change, giving both the old and new names."

10. Section 2225.5 of the Code states, in pertinent part:

"(a) (1) A licensee who fails or refuses to comply with a request for the medical records of a patient, that is accompanied by that patient's written authorization for release of records to the board, within 15 days of receiving the request and authorization, shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, unless the licensee is unable to provide the documents within this time period for good cause."

". . . .

"(e) Imposition of the civil penalties authorized by this section shall be in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Division 3 of Title 2 of the Government Code)."

11. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

12. Section 2264 of the Code states:

"The employing, directly or indirectly, the aiding, or the abetting of any unlicenced person or any suspended, revoked, or unlicenced practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct."

13. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

14. Section 2271 of the Code states: "Any advertising in violation of Section 17500, relating to false or misleading advertising, constitutes unprofessional conduct."

15. Section 2272 of the Code states: "Any advertising of the practice of medicine in which the licensee fails to use his or her own name or approved fictitious name constitutes unprofessional conduct."

16. Section 2285 of the Code states:

"The use of any fictitious, false, or assumed name, or any name other than his or her own by a licensee either alone, in conjunction with a partnership or group, or as the name of a professional corporation, in any public communication, advertisement, sign, or announcement of his or her practice without a fictitious-name permit obtained pursuant to Section 2415 constitutes unprofessional conduct. This section shall not apply to licensees who contract with, are employed by, or are on the staff of, any clinic licensed by the State Department of Health Services under Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code or any medical school approved by the division or a faculty practice plan connected with such a medical school."

17. Section 2306 of the Code states:

"If a licensee's right to practice medicine is suspended, he or she shall not engage in the practice of medicine during the term of such suspension. Upon the expiration of the term of suspension, the certificate shall be reinstated by the Division of Medical Quality, unless the licensee during the term of suspension is found to have engaged in the practice of medicine in this state. In that event, the division shall revoke the licensee's certificate to engage in the practice of medicine."

18. Section 2407 of the Code states: "A medical or podiatry corporation shall be subject to the provisions of Sections 2285 and 2415."

19. Section 2415 of the Code states, in pertinent part:

"(a) Any physician and surgeon or any doctor of podiatric medicine, as the case may be, who as a sole proprietor, or in a partnership, group, or professional corporation, desires to practice under any name that would otherwise be a violation of Section 2285 may practice under that name if the proprietor, partnership, group, or corporation obtains and maintains in current status a fictitious-name permit issued by the Division of Licensing, or, in the case of doctors of podiatric medicine, the California Board of Podiatric Medicine, under the provisions of this section."

20. Section 17200 of the Code provides, in part, that unfair competition

includes "any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising" and any act prohibited by Section 17500 *et seq.*

21. Section 17500 of the Code provides, in part:

"It is unlawful for any person, firm, corporation or association, or any employee thereof with intent directly or indirectly . . . to perform services, professional or otherwise, . . . or to induce the public to enter into any obligation relating thereto, to make or disseminate or cause to be made or disseminated before the public in this state, or to make or disseminate or cause to be made or disseminate from this state before the public in any state, . . . any statement, concerning . . . those services, professional or otherwise, . . . which is untrue or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue or misleading, or for any such person, firm, or corporation to so make or disseminate or cause to be so made or disseminated any such statement as part of a plan or scheme with the intent not to sell such personal property or services, professional or otherwise, so advertised at the price stated therein, or as so advertised."

22. Conduct which breaches the rules or ethical code of a profession or conduct which is unbecoming a member in good standing of a profession also constitutes unprofessional conduct. (*Shea v. Bd. of Medical Examiners*, (1978) 81 Cal.App.3d 564, 575.)

COST RECOVERY

23. Section 125.3 of the Code provides, in pertinent part, that the Division may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

MEDI-CAL REIMBURSEMENT

24. Section 14124.12 of the Welfare and Institutions Code states, in pertinent part:

"(a) Upon receipt of written notice from the Medical Board of California, the Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a licensee's license has been placed on probation as a result of a disciplinary action, the department

may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure, that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim, including any claim for dental services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence - Patient Maria S.)

25. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code in that he was grossly negligent in his care and treatment of patient Maria S. (also known as Socorro S.).[2] The circumstances are as follows:

26. On or about March 17, 2001, patient Maria S. visited Respondent's office to have him treat her varicose veins, but he did not perform such treatments. Instead, Maria S. agreed to have Respondent inject collagen into the wrinkles around her eyes, and paid him $300 to perform the procedure that day. According to Respondent's typed Patient Progress Notes, he injected 2 cc's of Zyplast collagen into the patient's bilateral crows feet wrinkles, with 8 total injection sites. The sites of the injections were not diagramed in the record.

27. Within days of the injections, patient Maria S. experienced swelling, redness and discomfort around her eyes. She returned to Respondent's office on or about March 23, 2001, and he treated her with anti-inflammatory injections of Dexamethasone to rule out allergic dermatitis.

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2. Initials are used in this pleading to protect patient privacy. Respondent will be provided with identifying information if discovery is requested.

28. On or about May 3, 2001, patient Maria S. returned to Respondent's office still complaining of swelling around the eyes. For a diagnosis, Respondent indicated "R/O [rule out] allergic dermatitis, unknown etiology," and treated her with injections of Dexamethasone and Kenalog. She also was prescribed Prednisone, 5 mg., 30 tabs.

29. Patient Maria S. last visited Respondent's office on or about November 13, 2001. She continued to complain of fullness and swelling around her eyes. Respondent's diagnosis, again, was "R/O allergic dermatitis, unknown etiology." He gave her an injection of the anti-inflammatory, Dexathasone, and prescribed Prednisone, 5 mg.

30. Patient Maria S. continued to have swollen, itchy eyes and she developed firm, rubbery, subdermal masses, yellowish in appearance, in both upper eyelids. The patient's subsequent treating physician referred her to Dr. Dresner, an Ophthalmic surgeon, for further evaluation, which was conducted on or about June 20, 2002. Dr. Dresner obtained a copy of Respondent's medical records for patient Maria S. Biopsies of the lumpy masses revealed a lymphohisticytic inflammation consistent with a reaction to a foreign body, which was consistent with silicone oil.[3] Patient Maria S. underwent surgery to remove the foreign material.

31. The following acts and omissions in Respondent's care and treatment of patient Maria S., taken singularly or collectively, constituted gross negligence:

a. Respondent failed to test, or to document that he tested patient Maria S. for an allergic reaction to Collagen or any other foreign substance prior to injecting her with the substance;

b. Respondent failed to inform, or to document that he informed patient Maria S. of the risks and complications of injecting Collagen or any foreign material in and around the eyes;

c. Respondent failed to advise, or to document that he advised patient Maria

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3. Liquid silicone has never been approved by the Federal Food and Drug Administration [FDA] for injection for cosmetic purposes. It is a Class III device which is the most heavily regulated type of device that has only been approved for ophthalmological diagnostic conditions, such as a detached retina.

S. of the risk of an allergic reaction to Collagen or to the injection of any foreign material around her eyes;

d. Respondent failed to offer to test patient Maria S. for an allergic reaction or to document that he offered the test, explained the risks and that the patient declined the allergy test before injecting her;

e. Respondent failed to wait, or to document that he informed patient Maria S. that it was important to wait at least 4 weeks after a skin test in order to prevent or detect an immediate or delayed allergic reaction, before injecting her with Collagen or other foreign material;

f. Respondent failed to document the lot number and expiration date of the Zyplast (a bovine product) that was injected into patient Maria S.; he failed to record information about the product that is necessary in order to report an adverse reaction, to trace the product for possible contamination or mislabeling, or to avoid using the product on another patient;

g. Respondent failed to provide patient Maria S. and the subsequent treating surgeon, Dr. Dresner, with a complete and accurate set of the patient's medical records. Respondent, or his office, failed to include the typed Patient Progress Notes that were provided to the Medical Board. The handwritten progress notes did not disclose the patient's history of a prior injection by a beautician, and did not contain details of a history, physical exam; the full name, dosage and amount of the drugs that were injected or prescribed; a description of the procedure, diagnosis, plan, and other information that should be contained in a medical record.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence - Patient Alicia C.)

32. Respondent is subject to disciplinary action under section 2234, subdivision (b) of the Code in that he was grossly negligent in his care and treatment of patient Alicia C. The circumstances are as follows:

33. On or about December 18, 2001, Alicia C. went to Respondent's office in

order to have him treat the wrinkles in her forehead. She had seen an advertisement for the "Olive Skin Clinic" in which Respondent claims he is a specialist in plastic surgery with years of experience in dermatology. Patient Alicia C. agreed to have Respondent inject collagen into the wrinkles on her forehead, and paid him $400 to perform the procedure that day. According to Respondent's typed Patient Progress Notes, he injected 2 cc's of Zyplast collagen over the patient's forehead and glabella areas, with a total of 10 injection sites. The sites of the injections were not diagramed in the record.

34. Within days of the injections, patient Alicia C. experienced swelling and bruising over the forehead. She returned to Respondent's office on or about December 20, 2001, and he treated her with an anti-inflammatory injection of Dexamethasone and prescribed Prednisone, 5 mg., 20 tabs. She was to return in one week.

35. On or about December 27, 2001, patient Alicia C. returned to Respondent's office still complaining of swelling and bruising around the forehead. Respondent noted the complaints were resolving and discontinued any medication.

36. The following acts and omissions in Respondent's care and treatment of patient Alicia C., taken singularly or collectively, constituted gross negligence:

a. Respondent failed to test, or to document that he tested patient Alicia C. for an allergic reaction to Collagen or any other foreign substance prior to injecting her with the substance;

b. Respondent failed to inform, or to document that he informed patient Alicia C. of the risks and complications of injecting Collagen or any foreign material in and around the forehead;

c. Respondent failed to advise, or to document that he advised patient Alicia C. of the risk of an allergic reaction to Collagen or to the injection of any foreign material around her forehead;

d. Respondent failed to offer to test patient Alicia C. for an allergic reaction or to document that he offered the test, explained the risks and that the patient declined the allergy test before injecting her;

e. Respondent failed to wait, or to document that he informed patient Alicia C. it was important to wait at least 4 weeks after a skin test in order to prevent or detect an immediate or delayed allergic reaction, before injecting her with Collagen or other foreign material;

f. Respondent failed to document the lot number and expiration date of the Zyplast (a bovine product) that was injected into patient Alicia C.; he failed to record information about the product that is necessary in order to report an adverse reaction, to trace the product for possible contamination or mislabeling, or to avoid using the product on another patient;

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

37. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the Code in that he was repeatedly negligent in his care and treatment of patients Maria S. and Alicia C. The circumstances are as follows:

38. The facts and allegations set forth in paragraphs 25 through 36, inclusive, constitute repeated negligent acts in the care and treatment of these two patients.

FOURTH CAUSE FOR DISCIPLINE

(Incompetence)

39. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code in that he was incompetent in his care and treatment of patients Maria S. and Alicia C. The circumstances are as follows:

40. The facts and allegations set forth in paragraphs 25 through 36, inclusive, constitute incompetence in the care and treatment of these two patients.

FIFTH CAUSE FOR DISCIPLINE

(Dishonesty and False Medical Records)

41. Respondent is subject to disciplinary action under sections 2234, subdivision (e), and 2261, in conjunction with section 2234, subdivision (a) of the Code in that he directly, and/or indirectly with the aid and assistance of others, made false statements,

prepared and maintained false, misleading, and inaccurate medical records concerning the care and treatment rendered to patients Maria S. and Alicia C. The circumstances are as follows:

42. The facts and allegations set forth in paragraphs 25 through 36 are incorporated here.

43. On a "Skin Assessment Form" dated 3/17/01, and signed by Maria Kaplan, an esthetician who had been working in Respondent's office for about 20 years, there was a notation that the "[patient] stated she had multiple injections of unknown material over both eyebrows [and] on lateral eye areas. This was approximately 5 to 6 months ago - patient can't remember dates. Injections were done by a beautician in salon, [patient] can't remember name. [Patient] did not see any change, claims they probably injected her with water;"

44. On a typed Patient Progress Note for March 17, 2001, there is a notation in the History section that "multiple bilateral brow and crows feet injections by beautician approx. 6 months ago unknown material, which produced no benefit." There is no notation about this history on the handwritten Patient Progress Notes for the March 17, 2001, visit;

45. Prior to the civil action that was filed by patient Maria S. against Respondent, and prior to the Board's request for records from Respondent, the set of records Respondent's office provided to patient Maria S. and to her subsequent surgeon, Dr. Dresner, did not contain the "Skin Assessment Form," or the typed Patient Progress Note with the history of prior injections. Respondent's office also had not provided the typed Patient Progress Notes for patient Maria S.'s visits on March 23, 2001, May 3, 2001, and November 13, 2001;

46. The handwritten Patient Progress Notes for patient Maria S.'s visits on March 17, 23, May 3, and November 13, 2001, do not contain the same details and information that is contained in the typed Patient Progress Notes for those visits. For example, the typed Progress Notes include information about a physical examination, diagnosis and treatment plan which are not included on the handwritten Progress Notes. Also, the blood pressure and temperature noted on the handwritten Progress Note are different from the ones noted on the typed Progress Notes for the visits on March 17 and 23, 2001.

47. Respondent testified at the civil trial and in the Board's interview that he

dictated Patient Progress Notes at the end of the day of a patient's visit, and he had Kennedy and Smith transcribe his dictation into the typed Patient Progress Notes in the files for patient Maria S. when, in fact, that company did not make or transcribe those records. The typed Patient Progress Notes that Respondent provided did not indicate the date they were dictated or transcribed.

48. On or about July 10, 2002, a letter was sent by the Board to Respondent notifying him about the complaint filed against him by patient Socorro S. (a.k.a. Maria S.). He was asked to provide a copy of her records by July 29, 2002.

49. On or about August 5, 2002, the Board received a Declaration of Custodian of Records, signed by Respondent and dated July 28, 2002. The Declaration certified that a thorough search had been conducted and the facility did not have the requested records.

50. Two more letters were sent by the Board requesting the records of Socorro S. The letter from the Board dated February 20, 2003, summarized the nature of the complaint that had been filed against him by patient Socorro S. The letter pointed out that Respondent previously had indicated he had no records for this patient, however the Board had obtained copies from the patient of progress notes for some of her visits, so it was apparent he did have records for this patient. The third letter requesting records was dated April 2, 2003. On or about April 28, 2003, the Board received fifteen (15) pages of medical records, partially written and partially transcribed, for patient Socorro S. from Respondent.

51. Respondent testified in the Board's interview and provided typed Patient Progress Notes for patient Alicia C. that purportedly were dictated to, and transcribed by Kennedy and Smith when, in fact, that company did not make or transcribe those records. The typed Patient Progress Notes that Respondent provided do not indicate the date they were dictated or transcribed.

52. The following statements and records are false, misleading, and/or inaccurate:

a. Respondent certified that he had no medical records for patient Socorro S. in response to the Board's requests for medical records when, in fact, he did have her

records;

b. Respondent's records indicate that patient Maria S. had multiple injections by a beautician, and when, in fact, she never told Respondent or his staff that she had such injections;

c. Respondent's typed Patient Progress Notes for patient Maria S. were not dictated to, and transcribed by Kennedy and Smith at or near the time of the patient's visits to Respondent's office

d. Respondent's typed Patient Progress Notes for patient Alicia C. were not dictated to, and transcribed by Kennedy and Smith;

e. The typed Patient Progress Notes for patient Maria S.'s visits on March 17, 23, May 3, and November 13, 2001, do not contain the same details and information that are contained in the handwritten notes for those visits;

f. The typed Progress Notes for March 17 and 23, 2001, include information about a physical examination, "heart normal," "chest clear," "neurological intact" when, in fact, Respondent testified he did not conduct a physical exam, he only looked at the patient;

g. The vital signs recorded for the visits on March 17 and 23, 2001, are inaccurate, and the information in the handwritten Progress Notes differs from the typed notes for those visits, with no notation or explanation for the differences in the records;

h. Respondent's office provided a set of records to patient Maria S. and the subsequent surgeon, Dr. Dresner, that was incomplete and inaccurate. The typed records were not provided and the handwritten records did not contain details of a history, physical exam, full name, dosage and amount of the drugs injected or prescribed to the patient, description of procedure, diagnosis, plan, and other information that should be contained in a medical record.

SIXTH CAUSE FOR DISCIPLINE

(Inadequate Medical Records)

53. Respondent is subject to disciplinary action under sections 2266 and 2234,

subdivision (a) of the Code in that he failed to maintain adequate and accurate records of the services provided to patients Maria S. and Alicia C. The circumstances are as follows:

54. The facts and allegations set forth in paragraphs 25 through 52, inclusive, constitute a failure to maintain adequate and accurate records of the services provided to these two patients.

SEVENTH CAUSE FOR DISCIPLINE

(Fictitious Name Permit Violations)

55. Respondent is subject to disciplinary action under sections 2234, subdivision (a), in conjunction with sections 2021, subdivision (c), 2271, 2272, 2285, 2415, 17200, and 17500 of the Code in that Respondent directly, or indirectly with the aid and assistance of others, practiced medicine, and held himself, or his professional corporation, out as practicing medicine, at several offices without informing the Board of the name changes and without obtaining fictitious name permits. The circumstances are as follows:

56. The facts and allegations set forth in paragraphs 25 through 52 are incorporated here by reference.

a. Respondent was issued a physician and surgeon certificate under the name of Jose Alfredo Martinez, M.D. His current address of record with the Board is Pacific Olive Medical Clinic, located at 7723 Pacific Boulevard, Huntington Park, California;

b. In or about December 1984, Respondent filed Articles of Incorporation for a professional corporation entitled Pacific Olive Medical Clinic;

c. On or about February 25, 1985, Respondent obtained from the Board a fictitious name permit to practice medicine under the name "Pacific Olive Medical Clinic." That permit was canceled on March 5, 2000, for non-payment of renewal fees. There currently is no valid fictitious name permit for "Pacific Olive Medical Clinic," though Respondent continues to practice medicine and holds himself out as able to practice medicine under that name;

d. In or about December 2001 to February 2002, Respondent advertised in the Spanish Weekly Magazine and T.V. Guide as a specialist in plastic surgery who did

collagen injections and eye surgery, and other procedures at "Olive Skin Clinic," located at his address of record 7723 Pacific Blvd., in Huntington Park. Patient Alicia C. sought Respondent's services after seeing this advertisement. Respondent does not, and did not, have a fictitious name permit issued by the Board to practice medicine under the name "Olive Skin Clinic;"

e. In or about November 2002, Maria Rivas Kaplan, who had worked with Respondent for about 20 years, applied for, and obtained a license for a business entitled "Namaste Skin Care and Body Care Clinic" (Namaste Clinic) that she owns and operates in Glendora. Kaplan is licensed as an esthetician by the Board of Barbering and Cosmetology. She is not licensed in any capacity by the Medical Board of California. According to Kaplan, Respondent has referred between forty (40) to sixty (60) patients from Pacific Olive Medical Clinic to Namaste Clinic for massage therapy mainly in workers compensation cases. He used to administer collagen injections at the clinic but now only works "on call" to treat patients with severe acne problems. To compensate Respondent, Kaplan stated she managed Respondent's personal accounts;

f. The window outside Namaste Clinic has a sign indicating "Jose Martinez, M.D., Medical Director. An advertisement for services at the clinic states "Dr. Jose Martinez, Medical Director." A framed photocopy of Respondent's Physician and Surgeon's Certificate hangs on the wall inside Namaste Clinic. The clinic had blank medical diagnostic sheets that were pre-signed with Respondent's name as the "Physician."

g. Respondent does not, and did not, have a fictitious name permit issued by the Board to practice medicine under the name "Namaste Skin Care and Body Care Clinic," and he did not inform the Board of this name change.

EIGHTH CAUSE FOR DISCIPLINE

(False and Misleading Advertising)

57. Respondent is subject to disciplinary action under sections 2234, subdivision (a), in conjunction with sections 119, 651, 652, 2271, 17200, and 17500 of the Code

in that Respondent directly, or indirectly with the aid and assistance of others, displayed a photocopy of his Physician and Surgeon's Certificate, and held himself out as the Medical Director at Namaste Skin Care and Body Care Clinic, a skin and body care clinic that was owned and operated by a person who was not licensed by the Medical Board. The circumstances are as follows:

58. The facts and allegations set forth in paragraphs 25 through 56 are incorporated here by reference.

59. Respondent displayed, or allowed others to display, a photocopy or reproduction of his Physician and Surgeon's Certificate on the wall in the reception area of the Namaste Clinic. He did not obtain a duplicate certificate as required by Medical Board regulations;

60. By holding himself out, and being held out as the Medical Director of Namaste Clinic, Respondent created, or helped to create, a false or unjustified expectation that the clinic was supervised or controlled by a medical practitioner, and gave a false impression of therapeutic legitimacy when, in fact, the clinic was owned and operated by a person who was not licensed by the Medical Board.

NINTH CAUSE FOR DISCIPLINE
AND
NOTIFICATION OF IMPOSITION OF CIVIL PENALTY

(Failure to Produce Records)

61. Respondent is subject to disciplinary action and to imposition of a civil penalty under sections 2225.5, in conjunction with 2234, subdivision (a) of the Code in that he failed or refused to comply with requests for the medical records of patient Maria S. and patient Alicia C., that were accompanied by the patients' written authorizations for release of records to the board, within 15 days of receiving the request and authorization. The circumstances are as follows:

a. The facts and allegations set forth in paragraphs 25 through 52, are incorporated here by reference;

b. On or about July 10, 2002, a letter was sent by the Board to Respondent

notifying him about a complaint that had been filed against him by patient Socorro S. (a.k.a. Maria S.). He was provided with a copy of the patient's signed Authorization for Release of Medical Records, and was asked to provide a copy of the records by July 29, 2002, along with a summary of the care and treatment he rendered to this patient. The letter advised Respondent that failure to produce the requested records may result in further action by the Board pursuant to section 2225.5 of the Code;

c. On or about August 5, 2002, the Board received a Declaration of Custodian of Records, signed by Respondent and dated July 28, 2002. The Declaration certified that a thorough search had been conducted and the requested records were not found;

d. On or about February 20, 2003, a letter was sent by the Board to Respondent summarizing the complaint filed against him by patient Socorro S. The letter pointed out that Respondent previously had indicated he had no records for this patient, however the Board had obtained copies from the patient of progress notes for some of her visits. Respondent was provided with a copy of the patient's signed Authorization for Release of Medical Records, and again was asked to provide a copy of the records by March 10, 2002, along with a summary of the care and treatment he rendered to this patient. The letter advised Respondent that failure to produce the requested records may result in further action by the Board pursuant to section 2225.5 of the Code;

e. On or about April 2, 2003, another letter was sent by the Board to Respondent requesting a copy of the records of patient Socorro S. by April 14, 2003, and advising him that failure to comply with this request could result in a civil penalty of $1,000 per day, pursuant to section 2225.5 of the Code;

f. On or about April 28, 2003, the Board received fifteen (15) pages of medical records, partially written and partially transcribed, for patient Socorro S. from Respondent, and a letter from his attorney dated April 21, 2003, describing the civil suit that was pending between Respondent and patient Socorro S., listing the medical records

that were being provided, and responding to the allegations of the patient in the complaint;

g. Respondent failed to provide the Board with a copy of the medical records he had for patient Socorro S. for over 285 days from the date of the first letter requesting the records and, thus, is subject to a civil penalty of at least $265,000.00, for not providing the records within fifteen (15) days of the request, as is required by section 2225.5 of the Code.

h. On or about February 19, 2003, a letter was sent by the Board to Respondent notifying him about a complaint that had been filed against him by patient Alicia C. He was provided with a copy of the patient's signed Authorization for Release of Medical Records, and was asked to provide a copy of the records by March 10, 2003, along with a summary of the care and treatment he rendered to this patient. The letter advised Respondent that failure to produce the requested records may result in further action by the Board pursuant to section 2225.5 of the Code;

i. On or about April 15, 2003, the Board received typed medical records for patient Alicia C. from Respondent, and a letter from his attorney dated April 9, 2003, responding to the allegations of the patient in the complaint;

j. Respondent failed to provide the Board with a copy of the medical records he had for patient Alicia C. for fifty-five (55) days from the date of the letter requesting the records and, thus, is subject to a civil penalty of $1,000 per day (approximately $36,000) for not providing the records within fifteen (15) days of the request (or by the March 10, 2003, deadline), as is required by section 2225.5 of the Code.

TENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

62. Respondent is subject to disciplinary action under Section 2234 of the Code in that he has committed unprofessional conduct and violated the rules and standards of his profession. The circumstances are as follows:

a. The facts and allegations set forth in paragraphs 25 through 61, including

all subparagraphs above, are incorporated here.

PRAYER

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

A. Revoking or suspending Physician and Surgeon's Certificate No. G 49769, issued to Jose Alfredo Martinez, M.D..

B. Revoking, suspending or denying approval of Jose Alfredo Martinez, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

C. Ordering Jose Alfredo Martinez, M.D. to pay the Division of Medical Quality the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring;

D. Ordering Jose Alfredo Martinez, M.D. to pay the Division of Medical Quality a civil penalty of $1,000 per day for each patient whose medical records he failed to produce within fifteen (15) days after receiving a signed written authorization to release the records;

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

DATED: June 3, 2004

DAVID T. THORNTON
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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