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

In the Matter of the Petition to Revoke ProbationAgainst:	)	
KHIN-KHIN GYI, M.D.	)	Case No. D1-2005-169885
Physician's and Surgeon's Certificate No. G 62062	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on October 12, 2012.

IT IS SO ORDERED: September 14, 2012.

MEDICAL BOARD OF CALIFORNIA

Janet Salomonson, M.D., Chair
Panel A

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

In the Matter of the Petition to Revoke Probation Against: **KHIN-KHIN GYI, M.D.** **10736 Jefferson Blvd., #704** **Culver City, Calif. 90230** **Physician's and Surgeon's Certificate No. G 62062** Respondent.	Case No. D1-2005-169885 OAH No. 2011120631 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Linda K. Whitney (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Edward K. Kim, Deputy Attorney General.

2. Respondent Khin-Khin Gyi, M.D. (Respondent) is represented in this proceeding by attorney Peter R. Osinoff, Esq., whose address is: 3699 Wilshire Boulevard, 10th Floor Los Angeles, California 90010-2719.

3. On or about August 31, 1989, the Medical Board of California issued Physician's and

Surgeon's Certificate No. G 62062 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Petition to Revoke Probation No. D1-2005-169885 and will expire on October 31, 2013, unless renewed.

JURISDICTION

4. Petition to Revoke Probation No. D1-2005-169885 was filed before the Medical Board of California, Department of Consumer Affairs, and is currently pending against Respondent. The Petition to Revoke Probation and all other statutorily required documents were properly served on Respondent on November 1, 2011. Respondent timely filed her Notice of Defense contesting the Petition to Revoke Probation.

5. A copy of Petition to Revoke Probation No. D1-2005-169885 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Petition to Revoke Probation No. D1-2005-169885. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Petition to Revoke Probation; the right to be represented by counsel at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her 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.

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

CULPABILITY

9. Respondent admits the truth of each and every charge and allegation in the First Cause to Revoke Probation in the Petition to Revoke Probation No. D1-2005-169885.

10. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

RESERVATION

11. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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

14. 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 Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 62062 issued to Respondent Khin-Khin Gyi, M.D. (Respondent) is revoked. However, the revocation is stayed

and Respondent is placed on probation for two (2) years on the following terms and conditions.

1. CLINICAL TRAINING PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in 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 twelve (12) 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 or any prior assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant, provided that the Program may revise any of the foregoing based on its prior evaluation of Respondent and the data it has obtained. 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 and any other data (as described in the preceding paragraph), 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.

Respondent shall not practice medicine until Respondent has successfully completed the

Program and has been so notified by the Board or its designee in writing, except that Respondent may practice in a clinical training program approved by the Board or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

2. PSYCHOTHERAPY. Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval the name and qualifications of a California-licensed board certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, Respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Board or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the Board or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Board or its designee. Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent.

Respondent shall have the treating psychotherapist submit quarterly status reports to the Board or its designee. The Board or its designee may require Respondent to undergo psychiatric evaluations by a Board-appointed board certified psychiatrist. If, prior to the completion of probation, Respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over Respondent's license and the period of probation shall be extended until the Board determines that Respondent is mentally fit to resume the practice of medicine without restrictions.

Respondent shall pay the cost of all psychotherapy and psychiatric evaluations.

3. MEDICAL EVALUATION AND TREATMENT. Within 30 calendar days of the effective date of this Decision, and on a periodic basis thereafter as may be required by the Board or its designee, Respondent shall undergo a medical evaluation by a Board-appointed physician (with appropriate expertise) who shall consider any information provided by the Board or designee and any other information the evaluating physician deems relevant and shall furnish a

medical report to the Board or its designee. Respondent shall provide the evaluating physician any information and documentation that the evaluating physician may deem pertinent.

Following the evaluation, Respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after being notified by the Board or its designee. If Respondent is required by the Board or its designee to undergo medical treatment, Respondent shall within 30 calendar days of the requirement notice, submit to the Board or its designee for prior approval the name and qualifications of a California licensed treating physician of Respondent's choice. Upon approval of the treating physician, Respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice from the Board or its designee.

The treating physician shall consider any information provided by the Board or its designee or any other information the treating physician may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician submit quarterly reports to the Board or its designee indicating whether or not the Respondent is capable of practicing medicine safely. Respondent shall provide the Board or its designee with any and all medical records pertaining to treatment, the Board or its designee deems necessary.

If, prior to the completion of probation, Respondent is found to be physically incapable of resuming the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over Respondent's license and the period of probation shall be extended until the Board determines that Respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

4. MONITORING – PRACTICE. Within 30 calendar days after Respondent has successfully completed the PACE clinical training program, 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 30 calendar days after Respondent has successfully completed the PACE clinical training program, 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 30 calendar days of successfully completing the PACE clinical training program, 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, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 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 calendar 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.

Notwithstanding anything to the contrary contained in this Disciplinary Order, in the event that Respondent's practice is monitored pursuant to this Condition 4, the period of probation shall be extended until Respondent has completed at least one (1) year of practice monitoring and the Board shall retain continuing jurisdiction over Respondent's license.

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.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

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).

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.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

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 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Peter R. Osinoff, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and

Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 8-15-12

KHIN-KHIN GYI, M.D.
Respondent

I have read and fully discussed with Respondent Khin-Khin Gyi, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 8/15/12

Peter R. Osinoff, Esq.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: 8-15-12

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
GLORIA L. CASTRO
Supervising Deputy Attorney General

EDWARD K. KIM
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Petition to Revoke Probation No. D1-2005-169885

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO November 1, 2011
BY: Telchin ANALYST

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

In the Matter of the Accusation and Petition to Revoke Probation Against: **KHIN KHIN GYI, M.D.** **10736 Jefferson Blvd., #704** **Culver City, CA 90230** **Physician's and Surgeon's Certificate No. G 62062,** Respondent.	**Case No. D1-2005-169885** **OAH Case No.** **ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

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

2. On or about August 31, 1989, the Medical Board of California issued Physician's and Surgeon's Certificate Number G62062 to Khin Khin Gyi, M.D. (Respondent). The Physician's and Surgeon's Certificate has been in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2011, unless renewed.

DISCIPLINARY HISTORY

3. On or about September 17, 2008, the Executive Director of the Medical Board filed

an Accusation against Respondent in the matter entitled: "*In the Matter of the Accusation Against Khin Khin Gyi, M.D.*," Medical Board Case No. 11-2005-169885.

4. On or about October 17, 2008, Respondent signed a Stipulated Settlement and Disciplinary Order to resolve the Accusation.

5. By order dated August 31, 2009, and effective September 30, 2009, regarding "*In the Matter of the Accusation Against Khin Khin Gyi*," Case No. 11-2005-169885, the Medical Board of California issued a Decision (Decision), revoking Respondent's Physician's and Surgeon's certificate to practice medicine. The revocation was stayed and Respondent's certificate was placed on probation for a period of thirty-five months with certain terms and conditions. A true and correct copy of the Decision is attached hereto as Exhibit A and is incorporated herein by reference as if fully set forth. Respondent's probation is set to expire on or about August 30, 2012.

JURISDICTION

6. This Accusation and Petition to Revoke Probation is brought before the Medical Board of California, under the authority of the following sections of the Business and Professions Code ("Code"):

7. Section 2220 of the Code states:

> "Except as otherwise provided by law, the Division of Medical Quality[1] may take action against all persons guilty of violating this chapter [Chapter 5, the Medical Practice Act]. The division shall enforce and administer this article as to physician and surgeon certificate holders, and the division shall have all the powers granted in this chapter . . . ."

8. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly

[1] Business and Professions Code section 2002, as amended effective January 1, 2008, provides in part that the term "board" as used in the Medical Practice Act (Business and Professions Code, section 2000, et seq.) means the "Medical Board of California," and that references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

reprimanded, or have such other action taken in relation to discipline as the Division deems proper.

9. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct.[2] 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. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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

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

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is

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[2] Unprofessional conduct is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

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."

10. 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."

PETITION TO REVOKE PROBATION

FIRST CAUSE TO REVOKE PROBATION

(Failure to Successfully Complete PACE Program)

11. Respondent's probation is subject to revocation because she failed to comply with Condition 2 of the Decision's Disciplinary Order (Condition 2) in that she failed to successfully complete the Physician Assessment and Clinical Education Program (PACE) offered at the University of California, San Diego School of Medicine. The circumstances are as follows:

12. At all times after the effective date of the Decision, Condition 2 stated, in pertinent part:

"The Program's determination as to whether Respondent passed the examination or successfully completed the Program shall be binding.

. . .

"Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

13. On or about December 1, 2010, Respondent, a neurologist, began her participation in the full seven-day PACE program (comprising Phase I and Phase II). Respondent attended PACE Phase I from December 1 to December 2, 2010. Respondent attended PACE Phase II from May 9 through May 13, 2011.

14. Respondent's performance in the PACE program was evaluated by PACE faculty and directors. They deemed Respondent's overall performance during PACE Phase I and Phase II as unsatisfactory. As a result, Respondent failed Phase I and II of PACE. Respondent's evaluators at PACE found that her overall performance was inconsistent with the ability to safely and successfully practice general neurology.

15. Respondent's failure to successfully complete the PACE program is a violation of the terms and conditions of her probation.

SECOND CAUSE TO REVOKE PROBATION

(Failure to Obey All Laws & Rules Related to the Practice of Medicine)

16. Respondent's probation is subject to revocation because she failed to comply with Condition 6 of the Decision's Disciplinary Order (Condition 6) in that she violated Code sections 2266 (by failing to maintain adequate and accurate medical records) and 2234, subdivision (c) (by being incompetent). The circumstances are as follows:

17. At all times after the effective date of Respondent's probation in Case No. 11-2005-169885, Condition 6 stated:

> "6. Obey All Laws. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments and other orders."

18. The allegations in the First Cause for Discipline below are incorporated herein by reference as if fully set forth.

19. Respondent showed a lack of medical knowledge and skill during her participation in PACE, and was thus incompetent, in violation of the Medical Practice Act, section 2234, subdivision (d), as described above in the First Cause for Discipline below.

20. Respondent failed to maintain adequate and accurate patient records with respect to her records that were submitted for evaluation pursuant to her participation in the PACE Physician Enhancement Program (PEP). [3]

[3] Pursuant to Condition 3 of the Decision's Disciplinary Order, Respondent could participate in the PEP program offered by PACE in lieu of having a practice monitor, which would include, a quarterly chart review, a semi-annual practice assessment, and a semi-annual (continued...)

FIRST CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

21. Respondent is subject to disciplinary action pursuant to Section 2234, in that Respondent engaged in general unprofessional conduct. The circumstances are as follows:

A. During PACE Phase I, Respondent performed a physical examination of a 27-year-old female mock patient. Respondent's examination of this mock patient was disorganized. She instructed the patient to lay down, stand, sit-up and sit, more times than necessary. In addition, Respondent incorrectly checked the patient's extra-ocular movements by checking vertical motions with the eyes midline.

B. Respondent underwent a computer based assessment of her cognitive skills, specifically, the Microcog cognitive screening test. Respondent performed in the low average to average range on all categories.

C. Respondent underwent an oral clinical examination and was presented with six patient scenarios. Respondent failed the oral clinical examination. Respondent's performance during these oral clinical examinations showed substantive deficiencies in all six patient scenarios, including (1) substantive deficiencies in basic neuroanatomy knowledge, as well as an inability to appropriately address the most common neurologic emergency, acute stroke; (2) substantive deficiencies in her ability to craft a comprehensive differential diagnosis; (3) substantive deficiencies in her knowledge of neuropathic pain agents; (4) substantive deficiencies in her knowledge of neuromuscular physiology and pharmacology; (5) substantive deficiencies in her ability to acutely manage meningitis, a common, life-threatening, neurologic emergency; and (6) substantive deficiencies in her knowledge of basic neuroanatomy and physiology.

D. Respondent participated in the PEP program. A PACE faculty member who served as Respondent's PEP monitor during her probation identified several issues with Respondent's practice through chart reviews and site visits. These issues

review of professional growth and education.

included: lack of organization, tardiness, unfocused patient encounters, incorrect diagnoses, and poor clinical decision making.

E. Respondent also took the Urgent Intervention/Acute Care version of PRIMUM, a computerized test developed by the National Board of Medical Examiners (NBME) designed to assess her knowledge of clinical decision-making and patient-management skills. Respondent scored in the bottom quartile on all eight cases, one of which was one standard deviation below average, and four of which were two standard deviations below average.

F. Respondent also took the following examinations: Ethics and Communication Examination (a multiple-choice test which assesses basic medical knowledge and knowledge of ethics and communication); Mechanism of Disease (a multiple-choice test which assesses basic science principle underlying medicine); and Psychiatry Clinic Science Subject Exam (which tests overall broad knowledge in the field of psychiatry). Respondent's performance on each of these exams was well below average. Respondent scored 30% on the neuropsychiatry/neurological-related disorders subsection of the Psychiatry Clinic Science Subject Exam.

G. During PACE Phase II, Respondent interacted with other physicians and students in multiple clinical and educational settings. Although Respondent made some comments about cases during her participation in Phase II, they often lacked attention to the fundamental properties of a case. For example, she seemed to have difficulty recognizing that the critical component of management and decision making in a patient, who is having episodic events, is to decide what the likely nature of the event is, prior to attempting to assess etiology. Furthermore, Respondent had difficulty with several basic anatomic relationships, including discussion of the spinothalamic tract, as well as discussion of spinal vasculature.

H. During PACE Phase II, Respondent was asked to participate in a written exercise. Her task was to identify in written narrative form (in no more than three pages) three things about her exposure at the University of California, San Diego

(UCSD) which she liked and were applicable to her practice, three things about her exposure at UCSD that she liked but felt were inapplicable to her practice, and at least one thing at UCSD that she had found that she did not like. She was asked to discuss her decision-making for these assessments. Respondent failed to deliver any response to this assignment.

I. Overall, Respondent failed Phase I and II of PACE. Respondent's evaluators at PACE found that Respondent's core anatomic knowledge and clinical decision making skills were deficient. They concluded that Respondent's clinical knowledge, judgment and behavior showed several deficiencies including, but not limited to, the following: (1) inadequate medical knowledge (her medical knowledge was frequently noted to be at the level of a junior resident); (2) inadequate clinical judgment; (3) lack of insight into her own skill and knowledge levels; (4) poor demonstration of professionalism and timeliness (she was late to several PACE clinic appointments); and (5) lack of understanding of the importance of timeliness in professional encounters and clinical care.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

22. Respondent is further subject to disciplinary action under section 2227 and 2234, as defined by section 2234, subdivision (d), in that Respondent has demonstrated incompetence. The circumstances are as follows:

23. The allegations in the First Cause for Discipline and First Cause to Revoke Probation above are incorporated herein by reference as if fully set forth.

24. Respondent showed a lack of skill and knowledge through her acts and omissions during her participation in PACE, from December, 2010 through May, 2011.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

25. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266 of the Code, in that she failed to maintain adequate and accurate records.

The circumstances are as follows:

26. The allegations in the First Cause for Discipline and First Cause to Revoke Probation above are incorporated herein by reference as if fully set forth.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G62062, issued to Khin Khin Gyi, M.D.

2. Revoking the probation that was granted by the Medical Board in case no. 11-2005-169885 and imposing the disciplinary order that was stayed thereby revoking Physician's and Surgeon's Certification G 65062 issued to Khin Khin Gyi, M.D.

3. Revoking, suspending or denying Khin Khin Gyi, M.D., the authority to supervise physician assistants, pursuant to section 3527 of the Code;

4. Ordering Khin Khin Gyi, M.D., to pay the costs of probation monitoring if she is placed on probation; and,

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

DATED: November 1, 2011.

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

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Exhibit A

Decision, Case No. 11-2005-169885

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

In the Matter of the Accusation Against:	)	
KHIN-KHIN GYI, M.D.	)	File No. 11-2005-169885
Physician's and Surgeon's Certificate No. G62062	)	
Respondent.	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on September 30, 2009.

IT IS SO ORDERED August 31, 2009.

MEDICAL BOARD OF CALIFORNIA

By: Shelton Duruisseau
Shelton Duruisseau, Ph.D., Chair
Panel A

EDMUND G. BROWN JR.
Attorney General of California
PAUL C. AMENT
Supervising Deputy Attorney General
EDWARD K. KIM
Deputy Attorney General
State Bar No. 195729
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **Khin-Khin Gyi, M.D.** **P.O. Box 3242** **Culver City, CA 90231** Physician's and Surgeon's Certificate No. G62062 Respondent.	Case No. 11-2005-169885 OAH No. 2008110077 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Barbara Johnston (Complainant) is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Edmund G. Brown Jr., Attorney General of the State of California, by Edward K. Kim, Deputy Attorney General.

2. Respondent Khin-Khin Gyi, M.D. (Respondent) is represented in this proceeding by attorney Peter R. Osinoff, whose address is 3699 Wilshire Boulevard, 10th Floor Los Angeles, CA 90010-2719. 2.1. On or about August 31, 1989, the Medical Board of California issued Physician's and Surgeon's Certificate No. G62062 to Khin-Khin Gyi, M.D.

(Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 11-2005-169885 and will expire on October 31, 2009, unless renewed.

JURISDICTION

3. Accusation No. 11-2005-169885 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on September 17, 2008. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 11-2005-169885 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

4. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 11-2005-169885. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

5. Respondent is fully aware of her 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 her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her 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.

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

CULPABILITY

7. Respondent admits that she committed acts or omissions in violation of Business and Professions Code section 2234, subdivision (c) and section 2266 based on her failure to elicit

or document sufficiently detailed histories and to perform or document a complete examination in at least one of the patients in Accusation No. 11-2005-169885.

8. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Medical Board of California's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

9. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

10. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary 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 Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G62062 issued to Respondent Khin-Khin Gyi, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for thirty-five (35) months on the following terms and conditions.

1. 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 6 months of probation is a violation of probation.

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

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

2. CLINICAL TRAINING PROGRAM No later than March 1, 2010, 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").

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 specialty or sub-specialty, 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. The Program's determination whether or not Respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after Respondent's initial enrollment unless the Board or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

If Respondent fails to complete the clinical training program within the designated time period, Respondent shall cease the practice of medicine within 72 hours after being notified by the Board or its designee that Respondent failed to complete the clinical training program.

Notwithstanding anything to the contrary contained herein, if during 2010, Respondent sits for and passes the written examination for recertification by the American Board of Psychiatry and Neurology, Inc., a member board of the American Board of Medical Specialties, and Respondent is thereafter recertified by the American Board of Psychiatry and Neurology, Inc., Respondent shall provide the Board or its agent proof of the recertification and, upon written notice from the Board or its agent acknowledging her recertification, Respondent may submit proof of such recertification in lieu of completing the Program.

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

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the

Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

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

The monitor shall submit quarterly written reports to the Board or its designee which include 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 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 Board or designee.

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

and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

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

4. NOTIFICATION Prior to engaging in the practice of medicine, 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. SUPERVISION OF PHYSICIAN ASSISTANTS During probation, Respondent is prohibited from supervising physician assistants.

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

7. QUARTERLY DECLARATIONS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. PROBATION UNIT COMPLIANCE Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an

address of record, except as allowed by Business and Professions Code section 2021(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.

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

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

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

Respondent's license shall be automatically cancelled if Respondent's periods of temporary or permanent residence or practice outside California total 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.

11. FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT

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

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

Respondent's 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.

12. COMPLETION OF PROBATION Respondent shall comply with all financial obligations (e.g., restitution and 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, Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation

shall be extended until the matter is final.

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

15. PROBATION MONITORING COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which costs 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.

ACCEPTANCE

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

DATED: _____

_____
KHIN-KHIN GYI, M.D.
Respondent

shall be extended until the matter is final.

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

15. PROBATION MONITORING COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which costs 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.

ACCEPTANCE

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

DATED: 7-15-09

KHIN-KHIN GYI, M.D.
Respondent

I have read and fully discussed with Respondent Khin-Khin Gyi, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 7/15/09 Calvin Vigil Esq for

Peter R. Osinoff
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: _____

Respectfully Submitted,

EDMUND G. BROWN JR.
Attorney General of California
PAUL C. AMENT
Supervising Deputy Attorney General

_____
EDWARD K. KIM
Deputy Attorney General
Attorneys for Complainant

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I have read and fully discussed with Respondent Khin-Khin Gyi, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: _____

_____
Peter R. Osinoff
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: 7/16/09

Respectfully Submitted,

EDMUND G. BROWN JR.
Attorney General of California
PAUL C. AMENT
Supervising Deputy Attorney General

_____
EDWARD K. KIM
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 11-2005-169885

EDMUND G. BROWN JR., Attorney General
of the State of California
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **KHIN KHIN GYI, M.D.** P.O. Box 3242 Culver City, CA 90231 Physician's and Surgeon's Certificate No. G62062 Respondent.	Case No. 11-2005-169885 OAH No. **ACCUSATION**

Complainant alleges:

PARTIES

1. Barbara Johnston (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about August 31, 1989, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate Number G62062 to Khin Khin Gyi, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2009, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless

otherwise indicated.

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

5. Section 2234 of the Code states:

"The Division of Medical Quality[1] 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. 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

---

1. California Business and Professions Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Cal. Bus & prof. Code, §§ 2000, et seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

and distinct breach of the standard of care.

"(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 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."

FACTUAL ALLEGATIONS

Factual Allegations re Patient M.R.[2]

7.A. On or about September 13, 2003, M.R., a 32-year old pregnant woman was admitted to Kaiser Permanente Hospital to delivery a baby. According to the patient chart dated September 14, 2003, no neurologic problems were recognized, and a note at 12:10 p.m. on that day stated that "no anesthesiology related complications" were present.

B. A note in M.R.'s patient chart made in the early hours on or about September 15, 2003, however, stated that M.R. was having difficulty walking and had pain in her inner thighs. Her examination by her attending physician and her nurses showed both proximal and distal weakness of legs. A note in M.R.'s patient chart in the early afternoon of that day reported improvement in pain and ability to bear weight, though M.R. continued to require a walker to ambulate to the bathroom and had continued dragging of both feet.

C. On or about September 15, 2003, Respondent performed a neurology consultation on M.R. M.R. had delivered a baby on September 13, 2003 after a 15-hour labor via vaginal delivery. In the section entitled "History of Present Illness" of her report for M.R., Respondent's notes were very brief, describing the complaint of pain on the inner aspect of the

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2. To ensure privacy, the patients are referred to by initials. In this proceeding, the true patient names, already known to Respondent, will be disclosed upon Respondent's timely written request for discovery pursuant to Government Code section 11507.6.

thighs, without specifying when the symptom began (before or after delivery), and no mention was made of weakness of the legs. The consultation report failed to indicate the time of onset of M.R.'s symptoms, e.g., whether her complaints began before or after the obstetric delivery, and further failed to describe the symptom of weakness. The neurologic examination described both proximal and distal weakness in both legs. Respondent's diagnosis was "the patient's signs and symptoms are entirely consistent with diabetic amyotrophy and distal neuropathy."

D. The progress notes of September 16, 2003, describe improvement in the patient's symptoms. A description of the motor examination suggests objective improvement in the weakness. The patient was discharged to her home with a walker on that day.

E. On or about October 17, 2003, Rodrigo Rodriguez, M.D., a neurologist, indicated in the patient's records that power in M.R.'s legs was normal, and the diagnosis was "recovering stretch injury of the lumbosacral plexopathy."

Factual Allegations re Patient I.J.

8.A. On or about March 27, 2004, I.J., a 30-year old woman was admitted to the emergency room complaining of numbness of the left arm, leg and body for 3 days, worsening on the evening of presentation. The results of a computed axial tomography (CT) brain scan on I.J. were normal. The emergency room physician's notes regarding impression includes "rule out TIA." The notes also state that the case had been discussed with a neurologist, and the disposition included an outpatient carotid Doppler study and blood tests.

B. On or about April 8, 2004, I.J. presented to Respondent for a neurological consultation. Respondent's brief patient notes on history did not give a clear account of the temporal aspect of the symptom. Her notes also mistakenly dates her emergency room visit to "April 27, 2004." Her notes also state that the "history of fatigue that progressed on to weakness" had been present for four (4) months, and that it lasted three (3) days and that "her symptoms would last two hours at a time when they would recur;" which was confusing. Additionally, the location and distribution of the "weakness" were not described. Her impression was transient ischemic attack (TIA). Her notes also indicated that carotid ultrasound tests were normal.

C. On or about January 9, 2005, I.J. presented to the emergency room complaining of weakness. The impression was "transient numbness now resolved likely due to stress/anxiety."

D. On or about January 14, 2005, I.J. presented to the family practice clinic of Kaiser complaining of left-sided weakness and burning. Neurology follow-up was requested.

E. On or about April 20, 2005, I.J., was seen in a neurology clinic by Jeanette Straga, M.D. The patients records for that day described I.J.'s primary problem as recurring headaches, some of which were associated with weakness of the left arm, lasting up to several hours. The notes also indicated that blood tests were normal, except for an elevation of protein S. I.J. was diagnosed with cephalgia and anxiety, and there was a recommendation that a magnetic resonance imaging (MRI) brain scan be performed on I.J. if the symptoms did not improve with the medications which were prescribed. There are no subsequent reports of an MRI scan of the brain in Respondent's records.

Factual Allegations re Patient J.C.

9.A. On or about July 20, 1999 and on or about August 16, 1999, patient J.C., was seen by neurologist, Barry Monroe, M.D. for evaluation of her balance problems. The diagnosis was possible benign positional vertigo. At the end of the first visit she also mentioned neck pain.

B. On or about January 30, 2002, J.C. complained to her primary physician, about a weakness on the left side of her face. A dictated neurology consultation report by Kim S. Yang, MD, dated February 14, 2002, states that the patient was 57-years old and describes subjective progressive weakness involving the left upper extremity which was felt to be possibly due to degenerative disease of the cervical spine. An MRI scan of the cervical spine was ordered and was performed on or about February 21, 2002; the results of which showed no abnormalities.

C. On or about February 20, 2004, J.C. presented to Respondent with a "Chief Complaint" recorded in her patient records as "left side of the mouth getting more droopy than the right side for the past two months associated with drooling." Respondent's notes also listed that J.C. complained that she "felt her left arm was more lazy. . ." Respondent's findings

that included that "examination does not reveal slurred speech and cranial nerves are grossly intact," and "but there is no pronator drift on examination." The "History of Present Illness" portion of Respondent's patient records of J.C. for that day states that "the patient returns today with her husband complaining of a 2-month history of subjective vertigo lasting a short while whenever she turns her head to the left." The remainder of that paragraph describes a motor vehicle accident and its other residua. There is no further description of the symptoms described in the chief complaint. A sentence in the neurologic examination of the patient records reads "There appears to be some facial asymmetry in that the left nasolabial fold is less pronounced than the right, but there is no aphasia or dysarthria." Under "Impression," Respondent wrote that:

> "When the patient was hit on the right side by the air bag, there may have been some concussion to the brain in the right hemisphere causing the left nasolabial fold to be less pronounced than the right. However, we do not have any x-rays of a facial series that were done from the time of her accident, therefore this is merely conjectural. The patient's vertigo may also be a reflection of a postconcussive syndrome. The positive Romberg sign deserves workup as well."

Respondent's plan for J.C. included a recommendation for "a facial CT," and she was given a laboratory slip for glucose tolerance test, B12 and folate levels, TSH and RPR "to rule out treatable causes of neuropathy."

D. A dictated note, dated May 17, 2004, by Respondent states that "Facial CT reveals sensory normal study except for right maxillary sinus for which the patient was not symptomatic today." Her "Impression" was "probable post concussive syndrome, causing the patient's recurrent memory loss these days." Respondent recommended that J.C. take vitamin E 400 international units twice a day with meals and to return to the neurology clinic as needed in the future. The report did not include any mention of the results of the blood tests which had been ordered by Respondent on the February 20, 2004 office visit.

E. On or about June 17, 2004, J.C. went to the emergency room in the early hours complaining of chest pain. On or about November 29, 2004, J.C. went to the emergency

room again with similar complaints. She was admitted to the hospital on both occasions.

Factual Allegations re Patient J.V.

10.A. On or about September 13, 2003, J.V., a 33-year old woman, presented to Respondent for a neurologic consultation for evaluation of right sided weakness. Respondent's chart for J.V. on that day, under the section "History of Present Illness," includes the following notes, "the patient was admitted to our hospital on 9/11/03 with gradual onset difficulty developing around 4 a.m. of that day . . ." and that J.V. had previously experienced an episode of right-sided weakness in April of that year at which time her MRI brain scan showed high signal lesions in the white matter. Her examination showed 4+/5 power in the right arm and leg and diminished pinprick sensation of the right arm and right leg. The impression was that the high signal lesions on flouro sequences on the MRI brain scan were highly suggestive of multiple sclerosis and that "indeed, the patient has two episodes that are separated in time and space and these are highly suggestive of multiple sclerosis as well." Respondent acknowledged in the history that J.V. had a hypercoagulable state.

B. The "Admission History and Physical" report, dated September 11, 2003, however, states that J.V. has a history of two strokes in the pulmonary embolus and right-sided weakness beginning on the day prior to admission. The report also stated that she had forgotten to take her Coumadin and that her CT brain scan showed a left temporal lobe low-density lesion consistent with an old infarct. The admitting internal medicine physician's diagnosis was stroke in a patient with a history of hypercoagulable states, prior strokes, DVT and pulmonary embolus.

C. J.V.'s discharge diagnosis, dated September 16, 2003, however, was multiple sclerosis with "Other Major Conditions" including history of CVA, hypercoagulable state and migraine headaches. The narrative of the hospital course in that discharge summary indicates that the diagnosis of multiple sclerosis was made by Respondent.

D. The dictated report from Presbyterian Intercommunity Hospital completed approximately six (6) weeks later, on or about November 3, 2003, indicates that the patient came to the emergency room complaining of headaches and right lower extremity weakness. Extensive neurologic evaluation was undertaken, and the statement was made the "she was ruled

out for multiple sclerosis."

E. An admission note, dated April 15, 2004, states that J.V. came to the emergency room with a migraine and right-sided weakness, and was known to have a hypercoagulable state.

F. A record of a hospital admission on or about July 19, 2004 indicated that J.V. was admitted for a hemi-plegic migraine and her neurology consultant was Rodrigo Rodriguez, M.D.

G. J.V. was 34 years old when she was hospitalized from May 15, 2006, to May 17, 2006, for a headache and a hypercoagulable state, for which she was treated with Coumadin. J.V. had a history of a previous stroke and also of pulmonary embolism and deep venous thrombosis.

Factual Allegations re Patient N.C.

11.A. On or about April 12, 1993, N.C., a 43-year old man, presented to Respondent with complaints of seizures and dragging on his right side. He had a one-year history of attacks of jerking movements in his right arm and leg lasting 40 seconds at a time, occurring chiefly at night, and awakening him from sleep. At that time N.C. was on Tegretol[3] for seizures, which had begun in 1962. His most recent seizure had been in 1987. His neurological examination, according to the note, was normal. The diagnosis was simple partial seizures "however, cannot rule out the possibility of fasciculations[4], which can be brought on cervical nerve root compression versus hyperparathyroidism[5] versus hypercalcemia[6]." The notes further stated that "Patient appears to have seizure disorder upon defined etiology, at least within the Kaiser system, and would help to establish the etiology, whether it be generalized epilepsy, as in genetic epilepsy, or whether it is acquired, as in complex partial seizure type of epilepsy." An

3. A anticonvulsant, antimanic drug used to prevent and control seizures.

4. Muscle twitch.

5. An overactivity of the parathyroid glands resulting in excess production of parathyroid hormone.

6. An elevation in calcium in the blood.

MRI scan of the cervical spine was ordered, and the patient was started on quinine.[7]

B. On or about July 27, 1993 N.C. underwent somatosensory evoked potential studies which showed abnormal responses in the median nerves which Respondent interpreted as suspicious for multiple sclerosis. The visual evoked potentials performed on or about August 10, 1993 were normal. The posterior tibial somatosensory evoked potentials performed on or about August 12, 1993, were abnormal due to a difference between the two sides.

C. In her dictated consult report, dated August 29, 1993, Respondent described N.C. as having a history of multiple sclerosis for eight (8) months. The examination showed mild ataxia on tandem gait testing and decreased rapid alternating movements in the left upper and left lower extremities. "Sensory testing revealed positive Romberg sign. There was decreased perception of vibration in the right extensor hallucis. Position sense was similarly involved." Respondent's impression was of "mild relapse of multiple sclerosis, with mild in fall of two systems (cerebellar and sensory), now resolved by 75% in terms of vertigo. This appears to be the fourth relapse the patient has experienced this year."

D. Thereafter, Respondent continued to treat N.C. for multiple sclerosis.

E. On or about September 17, 2001, Respondent saw N.C. and noted that he was getting weaker and using a sit-down walker. He was still not using Copaxone. She prescribed that he restart Copaxone by injection.

F. Respondent saw N.C. next on or about April 1, 2002. She noted that N.C. had stopped the Copaxone[8] for which arrangements were made for a home health nurse to administer his injections.

G. Respondent saw N.C. on or about September 23, 2002 and noted that N.C. had five falls in the previous three months due to his left leg giving out. Her notes also indicated

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7. Quinine is used to treat nocturnal leg cramps and arthritis, among other things.

8. A drug used to treat multiple sclerosis.

that N.C. was no longer taking Copaxone or Remeron.[9] On examination, she found him to be forgetful.

H. Respondent saw N.C. on or about January 13, 2003 and the patient chart for that day described a decubitus ulcer in the right leg.

I. Respondent saw N.C. on or about February 27, 2003, and the patient chart for that visit noted that N.C. was falling a lot, leading to her diagnosis of multiple sclerosis in relapse. He was restarted on Copaxone.

J. Respondent then saw N.C. on or about June 16, 2003. The patient chart for that day reported that N.C. had a shuffling gait for two months and "now walks with bilateral foot drop." Respondent's plan was to perform a peripheral neuropathy panel, and N.C. was given a lab slip for blood tests.

K. Respondent next saw N.C. on or about August 21, 2003, for follow-up of multiple sclerosis. The progress notes for that day reported that N.C. ran out of money and could not get money for his Copaxone. He was also taking Tegretol. He was given free samples of Copaxone.

L. On or about November 21, 2003, Respondent saw N.C. for weight loss and worsening of multiple sclerosis. On that day, Respondent admitted N.C. to the hospital because of his inability to feed himself or take his medications on a consistent basis. The patient chart for that day under the section, "History of Present Illness," provided that N.C. had secondary progressive multiple sclerosis, a past history of alcohol abuse, chronic obstructive pulmonary disease and depression and had not been taking his medications and was unable to manage activities of daily living. Regarding neurologic exam, N.C. was awake but disoriented. His speech was slightly slurred. He had mild weakness in both legs and tendon reflexes were 1+. His gait was wide based and ataxic. His urinalysis showed 10 to 25 white blood cells and many bacteria. The differential diagnosis was diminished cognitive capacity due to multiple sclerosis or alcohol dementia. He was treated with ampicillin. N.C. was discharged from the hospital on or

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9. A drug used to treat the symptoms of moderate to severe depression.

about November 30, 2003. The discharge summary was prepared by Philip Stephens, M.D. During the hospitalization N.C.'s mental status improved, though he had a seizure. The discharge summary notes provided that N.C. underwent a lumbar puncture and the results of MRI scanning were without evidence of multiple sclerosis. N.C. was said to be ambulatory with a walker.

M. An MRI brain scan report of N.C., dated November 25, 2003, indicated that N.C. exhibited no evidence of multiple sclerosis plaque, but that N.C. had minimal periventricular and subcortical nonspecific focal white matter changes. No change was noted when the MRI was compared to a prior MRI study dated November 16, 2000. Usual spinal fluid results were not present though a spinal tap on N.C. was performed on November 25, 2003. N.C.'s cryptococcus antigen and India ink studies were normal. N.C.'s Gram stain and RPR, which are usually performed on spinal fluid, dated November 25, 2003 were also normal; although the results did not specifically state that they were performed on spinal fluid. In the handwritten progress notes the cerebrospinal fluid protein was noted to be 39 and a glucose 70. However, a laboratory report of spinal fluid protein, glucose, cell count or multiple sclerosis studies was not present. A handwritten note dated November 25, 2003, stated that Respondent's diagnosis of multiple sclerosis was based on a plaque in N.C.'s cervical spine MRI.

N. On or about December 2, 2003, Respondent saw N.C. as a follow-up to N.C.'s recent hospitalization and his seizures and altered mental status. He had suffered a seizure on the day prior to the visit. His Tegretol blood level was 5.6. Respondent attributed the seizure to a low Tegretol level consequent to lowering of the Tegretol dose during the recent hospitalization.

O. On or about January 19, 2004, Respondent saw N.C. for follow up on his multiple sclerosis and seizures. She indicated that N.C. had no seizures on Tegretol. Her notes stated, "[t]he patient has not filled out his prescription of clonazepam, which we have given him for seizure prophylaxis in addition to his Tegretol." N.C.'s Tegretol blood level was said to be 11.7 and was described as "very therapeutic." Under Recommendations, the report noted that "the patient appears to have jerky movement of his legs, which is a precursor to his having his complex partial seizures. This is most likely due to his lack of reinitiating treatment with

clonazepam." N.C. was referred to physical therapy for evaluation for a wheelchair.

P. Respondent's admission "History and Physical" report, dated October 12, 2004, stated that N.C. had been in his usual state of health "until he ingested ethnic food on Monday 10/11/04, and then had nausea and vomiting 5 times as well as dizziness beginning on 10/12/04." She noted that his prior multiple sclerosis relapses had usually included dizziness. His serum sodium was 124, and his urinalysis showed many bacteria, but did not mention white blood cells. Respondent's diagnosis was dehydration secondary to nausea and vomiting "but cannot rule possibility of gastritis or peptic ulcer disease as the patient did have an extensive history of ethyl alcohol [ETOH] use in the past." Respondent ordered an upper GI series[10] on N.C., started him on ranitidine,[11] and ordered a "workup for symptom of inappropriate anti-diuretic hormone. . ."[12]

Q. On or about March 9, 2005, N.C. was admitted to Citrus Valley Medical Center with an altered level of consciousness. He was transferred to Kaiser Baldwin Park Medical Center on or about March 14, 2005, with multiple medical problems cited. On or about February 17, 2005, N.C. was seen in neurologic consultation by Rodrigo Rodriguez, M.D. who reviewed N.C.'s history and records of his multiple sclerosis. Dr. Rodriguez' impression was that the neurologic examination localizes to the C-spine area with what appears to be a cervical myelopathy.[13] He recognized that N.C. had had cervical disk disease in the past. A repeat MRI scan of the cervical spine was ordered. The results of an EEG[14] dated March 14, 2005, were abnormal due to slow activity. The plain x-ray of the cervical spine on April 12, 2005, showed a

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10. An upper GI (gastrointestinal) series, or barium swallow, is a radiology test which is used to visualize the structures of the upper digestive system (the esophagus, stomach and duodenum).

11. A drug which inhibits stomach acid production.

12. N.C. was taking Tegretol, which can cause hyponatremia, an electrolyte disturbance (disturbance of the salts in the blood) in which the sodium concentration in the plasma is too low. Severe or rapidly progressing hyponatremia can result in swelling of the brain.

13. Myelopathy is a disorder in which the tissue of the spinal cord is diseased or damaged.

14. Electroencephalography (EEG) is a test that measures and records the electrical activity of your brain by using sensors (electrodes) attached to the head.

fusion at C3 and C4, large osteophytes anteriorly at several levels, but no significant central canal stenosis. On or about September 22, 2005, N.C. underwent a cervical spine operation for progressive cervical myelopathy.

Factual Allegations re Patient B.H.

12.A. On or about March 26, 2004, B.H., a 16-year old male, presented to Respondent for evaluation for headaches. Written under the section "Chief Complaint" in Respondent's patient chart for that day was an extensive synthesis of the case, including her impressions and recommendations. Respondent noted that B.H. was taking doxycycline[15] for acne. The chart indicated that B.H.'s headaches were "persistent." The physical examination did not include evaluation of ocular fundi. The final impression was of "dietary induced migraines" because B.H. had consumed peanut products, including peanut butter and assorted snack foods. Respondent counseled B.H. about dietary issues. She also ordered a CT brain scan for B.H.

B. The results of B.H.'s CT brain scan conducted on or about April 12, 2004, showed an arachnoid cyst in the posterior fossa. This was described as a large cystic structure in the posterior fossa, extending into the occipital lobe. The radiologist noted in the report that it had slight mass effect and deviation of the midline dura to the right side.

C. On or about March 4, 2005, an optometry evaluation was performed on B.H.

Factual Allegations re Patient P.P.

13.A. An orthopedic Outpatient Consultation report dated May 6, 1998, indicates that P.P. presented with complaint of difficulty flexing his left thumb for two months. For three weeks prior to the evaluation P.P. had experienced numbness and tingling in the left thumb, index and middle fingers. He had a history of trauma to those digits 40 years earlier. The orthopedic consultant's diagnoses included left trigger thumb and probable left carpal tunnel syndrome.

B. An MRI scan of the internal auditory canals was performed on or about

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15. An antibiotic commonly used to treat a variety of infections.

May 23, 2000 was interpreted as normal.

C. A Consultation Request on or about May 25, 2001, describes P.P. as a 67-year-old man with right sided throbbing headaches which awakened him from sleep.

D. On or about July 6, 2001, P.P. was seen by Respondent. In her patient chart for that day, under the section "Chief Complaint," was a 5½ line paragraph of historical information including the complaint of right sided throbbing headaches which awakened him from sleep for the past 6 to 8 months. The history was described as intermittent headaches which occurred two to three times a week, awakening him from sleep, lasting for 30 minutes and associated with bloodshot eyes, runny or stuffy nose and worse with movement. The neurological examination was indicated as normal. The impression was of "dietary induced migraines as he does ingest cold cuts laden with sodium nitrate preservatives and Chinese food laden with monosodium glutamate [and that temporal] arteritis should be ruled out . . ." He was given a list of migraine triggering foods that he should avoid and a laboratory slip for a sedimentation rate.

E. A hand written medical consult report dated July 31, 2003, reports a 3 day history of weakness, lightheadedness and myalgia. P.P. was 70 years old when he was hospitalized from August 1 through August 4, 2003, for urosepsis. Other medical diagnoses included coronary artery disease, hypertension, hyperlipidemia chronic obstructive pulmonary disease.

F. P.P. was again seen by Respondent on March 25, 2004. Although the handwritten note in P.P.'s chart for that day is not completely legible, his complaint appears to be of left hand numbness since August 2003, "when he had stents placed on 10/21/03 at Sunset. His handwriting is now becoming illegible." The impression was possible CVA versus mononeuropathy and a CT scan was ordered. In a dictated report for that visit under "Chief Complaint," is a six line paragraph including the history of three months of loss of motor control of the left thumb as well as the physical finding of loss of two-point discrimination on all fingers of the left hand. The report states that "strength in the upper extremities was 5/5 for the interossei bilaterally as well as for the abductor pollicis brevis bilaterally. Abductor digit minimi

was also 5/5 bilaterally." Also noted was diminished temperature sensation below the elbows bilaterally. The impression was that there appeared to be evidence of peripheral neuropathy, most likely secondary to diabetes, "but will also rule out right hemispheric cerebrovascular accident (CVA) that might account for the patient's left hand numbness."

G. On or about July 6, 2004, electrodiagnostic studies were performed on P.P. by another physician, the results of which showed findings consistent with left carpal tunnel syndrome and mild right carpal tunnel syndrome.

H. On or about June 4, 2004, Respondent saw P.P. again and wrote in the patient chart for that day, which is not completely legible, but seems to indicate that symptoms improved with injection of 2% lidocaine. Her diagnosis was "suspect left thumb osteoarthritis."

I. Inserted within the extensive medical records of P.P.'s August 2003 hospitalization is a release form for performing a left carpal tunnel operation, dated August 18, 2004. A left carpal tunnel release operation was performed on P.P. on or about August 18, 2004.

Factual Allegations re Patient C.R.

14.A. On or about February 3, 1984, C.R., a 49-year old woman, was seen by an ophthalmologist with findings of disk edema in the left eye, and was treated with corticosteroids. Follow-up notes and the following month indicate that she was improving. Ophthalmology notes in 1989 and 1992 indicate that C.R. had multiple sclerosis. An MRI brain scan was normal on January 7, 1992. A letter dated May 28, 1993, from neurologist Andrew C. Carr, M.D., addressed to a disability agent, indicated that C.R. had a tentative diagnosis of multiple sclerosis on the basis of her symptoms and the optic neuropathy, though it stated that they spinal tap was normal for "MS panel." A letter from the Royalty Medical Group, dated March 9, 1993, summarize the course of C.R.'s multiple sclerosi. Electrodiagnostic studies on or about July 28, 1994 showed mild to moderate bilateral carpal tunnel syndrome.

B. On or about December 16, 1997, Respondent saw C.R. Her patient chart under history describes C.R.'s five exacerbations of symptoms of multiple sclerosis, and Respondent's impression was "relapsing, progressive MS, with 5 relapses to her history, with the last episode being in 1993 of record." She was treated with an antidepressant

and a physical therapy referral.

C. A report of an MRI brain scan dated May 15, 2000, described multiple punctate areas of T2 hyperintensity in both hemispheres and brainstem, consistent with ischemia, with no mention of multiple sclerosis.

D. On or about April 16, 2001, Respondent made a note in C.R.'s chart that C.R. had intermittent blurred vision in her left eye, and a one day history of dizziness.

E. Thereafter, Respondent continued to treat C.R. for multiple sclerosis.

F. On or about January 21, 2002, Respondent made a note in C.R.'s chart that indicates that a course of Solu-Medrol[16] did not improve her vision, and stated that Novantrone[17] was considered.

G. On or about January 31, 2002, C.R. underwent an echocardiogram, the results of which were normal.

H. An order for Novantrone infusion for C.R. was dated March 6, 2002.

I. A progress note of C.R. by Respondent dated August 15, 2003, concluded that C.R.'s multiple sclerosis was stable. A notation for that day also indicated that C.R. was receiving Novantrone every three months to slow progression of her multiple sclerosis.

J. A progress note by neurologist, Qian Zhang, M.D., dated July 19, 2004, reviewed the history of symptoms and lab results, including apparent exacerbations and remissions of visual symptoms and normal cerebrospinal fluid multiple sclerosis panel and MRI brain scan showing non-diagnostic T2 hyperintensities, though one on a scan of 2000 was said to involve the corpus callosum.

K. A report of a MRI brain scan with gadolinium dated September 10, 2004, showed multiple small, non-enhancing white matter lesions consistent with, but not diagnostic of multiple sclerosis, along with mild atrophy, consistent with the patient's age.

L. Dr. Zhang reported in note dated October 13, 2004, that the MRI·

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16. A drug used to treat multiple sclerosis.

17. A drug used to treat multiple sclerosis.

abnormalities were unchanged from earlier studies and were not characteristic of multiple sclerosis.

M. On or about November 23, 2004, Dr. Zhang performed a lumbar puncture. In a note, dated January 3, 2005, the cerebrospinal fluid was stated to be normal, with negative multiple sclerosis panel. Another note by Dr. Zhang on that same day stated her opinion that MRI lesions were due to microvascular disease and visual complaints due to ischemic optic neuropathy and not to multiple sclerosis. Because of complaints of back pain and foot numbness, an MRI scan of C.R.'s LS spine[18] was ordered.

N. On or about January 26, 2005, an MRI scan of C.R.'s LS spine was performed. The results of that scan showed degenerative changes without canal stenosis. An MRI scan of C.R.'s thoracic spine on or about January 22, 2005 also showed degenerative changes.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

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

Allegations of Gross Negligence re Patient M.R.

A. On or about September 15, 2003 and thereafter, Respondent was grossly negligent in her care and treatment of patient M.R. by incorrectly diagnosing M.R. with diabetic amyotrophy and distal neuropathy based on her faulty reasoning and failure to consider other diagnoses in her differential analysis and failure to elicit sufficiently detailed histories and failure to perform thorough examinations of the patient. The facts and circumstances, set forth in paragraphs 7.A. through 7.E. of this Accusation are incorporated here as if fully set forth.

Allegations of Gross Negligence re Patient J.V.

B. On or about September 13, 2003 and thereafter, Respondent was grossly

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18. Lumbo Sacral Spine.

negligent in her care and treatment of patient J.V. by incorrectly diagnosing J.V. with multiple sclerosis based on her faulty reasoning and failure to consider other diagnoses in her differential analysis and failure to elicit sufficiently detailed histories and failure to perform thorough examinations of the patient. The facts and circumstances, set forth in paragraphs 10.A. through 10.G. of this Accusation are incorporated here as if fully set forth.

Allegations of Gross Negligence re Patient N.C.

C. On or about September 17, 2001 and thereafter, Respondent was grossly negligent in her care and treatment of patient N.C. by incorrectly diagnosing N.C. with multiple sclerosis based on her faulty reasoning and failure to consider other diagnoses in her differential analysis and failure to elicit sufficiently detailed histories and failure to perform thorough examinations of the patient. The facts and circumstances, set forth in paragraphs 11.A. through 11.Q. of this Accusation are incorporated here as if fully set forth.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

16. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that respondent engaged in repeated negligent acts in the care and treatment of patients. The circumstances are as follows:

Allegations of Negligence re Patient M.R.

A. The acts and/or omissions set forth in paragraph 15.A. above constitute departures from the standard of care. The facts and circumstances, set forth in paragraphs 7.A. through 7.E. of this Accusation are incorporated here as if fully set forth.

Allegations of Negligence re Patient I.J.

B. On or about April 8, 2004 and thereafter, Respondent was negligent in her care and treatment of patient I.J. by:

(1) incorrectly diagnosing I.J. with transient ischemic attack based on her faulty reasoning and failure to consider other diagnoses in her differential analysis and failure to elicit sufficiently detailed histories and failure to perform thorough examinations of the patient; and

(2) failing to maintain adequate and accurate medical records of I.J., including in her neurology consultation report dated April 8, 2004, which was extremely confusing, e.g., the description of I.J.'s symptoms, and did not conform to the standard of care.

The facts and circumstances, set forth in paragraphs 8.A through 8.E. of this Accusation are incorporated here as if fully set forth.

Allegations of Negligence re Patient J.C.

C. On or about February 20, 2004 and thereafter, Respondent was negligent in her care and treatment of patient J.C. by:

(1) failing to maintain adequate and accurate medical records of J.C., including in her notes in the patient chart, dated February 20, 2004, regarding J.C.'s history and current symptoms, which were confusing; and combining the physical findings on the examination of J.C. with the elements of her history; and

(2) incorrectly diagnosing J.C. and arriving at unsupported conclusions in her impressions, e.g., her attributing the nasolabial fold to a cerebral concussion.

The facts and circumstances, set forth in paragraphs 9.A through 9.E. of this Accusation are incorporated here as if fully set forth.

Allegations of Negligence re Patient J.V.

D. The acts and/or omissions set forth in paragraph 15.B. above constitute departures from the standard of care. The facts and circumstances, set forth in paragraphs 10.A. through 10.G. of this Accusation are incorporated here as if fully set forth.

Allegations of Negligence re Patient N.C.

E. The acts and/or omissions set forth in paragraph 15.C. above constitute departures from the standard of care. The facts and circumstances, set forth in paragraphs 11.A. through 11.Q. of this Accusation are incorporated here as if fully set forth.

Allegations of Negligence re Patient B.H.

F. On or about March 26, 2004 and thereafter, Respondent was negligent in her care and treatment of patient B.H. by:

(1) incorrectly diagnosing B.H. with chronic headaches caused by the consumption of peanut products based on her faulty reasoning and failure to consider other diagnoses in her differential analysis and failure to elicit sufficiently detailed histories and failure to perform thorough examinations of the patient.

(2) failing to examine the ocular fundi[19] of B.H.; and

(3) failing to maintain adequate and accurate medical records of B.H., including her patient records dated March 26, 2004, which were poorly written, and did not conform to the standard of care.

The facts and circumstances, set forth in paragraphs 12.A through 12.C. of this Accusation are incorporated here as if fully set forth.

Allegations of Negligence re Patient P.P.

G. On or about September 17, 2001 and thereafter, Respondent was negligent in her care and treatment of patient P.P. by:

(1) failing to diagnose P.P. with carpal tunnel syndrome, notwithstanding all of the evidence indicating a diagnosis of carpal tunnel syndrome, based on her faulty reasoning and failure to consider other diagnoses in her differential analysis and failure to elicit sufficiently detailed histories and failure to perform thorough examinations of the patient; and

(2) failing to maintain adequate and accurate medical records of P.P. in that her patient records for P.P. were poorly written, and did not conform to the standard of care.

The facts and circumstances, set forth in paragraphs 13.A. through 13.I. of this Accusation are incorporated here as if fully set forth.

Allegations of Negligence re Patient C.R.

H. On or about September 17, 2001 and thereafter, Respondent was negligent in her care and treatment of patient C.R. by:

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19. The portion of the interior of the eyeball around the posterior pole, visible through the ophthalmoscope.

(1) incorrectly diagnosing C.R. with multiple sclerosis based on her faulty reasoning and failure to consider other diagnoses in her differential analysis and failure to elicit sufficiently detailed histories and failure to perform thorough examinations of the patient; and

(2) failing to maintain adequate and accurate medical records of P.P. in that her patient records for P.P. were poorly written, and did not conform to the standard of care.

The facts and circumstances, set forth in paragraphs 14.A. through 14.N. of this Accusation are incorporated here as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

17. Respondent is subject to disciplinary action under section 2234, subdivision (d), of the Code in that respondent was incompetent in the care and treatment of patients. The circumstances are as follows:

A. The allegations of the First and Second Causes for Discipline are incorporated herein by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Keep Adequate and Accurate Records)

18. Respondent is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to keep adequate and accurate records related to the provision of medical services to patients. The circumstances are as follows:

A. The allegations of the First, Second and Third Causes for Discipline are incorporated herein by reference as if fully set forth.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 62062, issued to Khin Khin Gyi, M.D.;

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

3. Ordering Khin Khin Gyi, M.D. to pay the Board, if placed on probation, the costs of probation monitoring;

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

DATED: September 17, 2008

BARBARA JOHNSTON
Executive Director
Medical Board of California
State of California, Complainant

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