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

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| **In the Matter of the First Amended Accusation Against**<br><br>**Madhava Reddy Narala, M.D.**<br><br>**License No. A 51494**<br><br>**Respondent.** | **Case No. 800-2015-014001** |

## 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 May 29, 2020.**

**IT IS SO ORDERED: April 29, 2020.**

**MEDICAL BOARD OF CALIFORNIA**

**Kristina D. Lawson, J.D.**
**Panel B**

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
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*Attorneys for Complainant*

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

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| In the Matter of the First Amended Accusation Against:<br><br>**MADHAVA REDDY NARALA, M.D.**<br>**568 East Herndon, Suite 102**<br>**Fresno, CA 93720**<br><br>**Physician's and Surgeon's Certificate No. A 51494**<br><br>Respondent. | Case No. 800-2015-014001<br><br>OAH No. 2019020279<br><br>**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. Christine Lally (Complainant) is the Interim 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 Xavier Becerra, Attorney General of the State of California, by Michael C. Brummel, Deputy Attorney General.

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2. Respondent Madhava Reddy Narala, M.D. (Respondent) is represented in this proceeding by attorney Dirk B. Paloutzian, Esq., whose address is: 5260 North Palm Avenue, Fourth Floor, Fresno, CA 93704.

3. On or about December 7, 1992, the Board issued Physician's and Surgeon's Certificate No. A 51494 to Madhava Reddy Narala, 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 First Amended Accusation No. 800-2015-014001, and will expire on June 30, 2018, unless renewed.

## JURISDICTION

First Amended Accusation No. 800-2015-014001 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on February 6, 2019. Respondent timely filed his Notice of Defense contesting the First Amended Accusation.

4. A copy of First Amended Accusation No. 800-2015-014001 is attached as Exhibit A and incorporated herein by reference.

## ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2015-014001. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

## CULPABILITY

8. Respondent understands and agrees that the charges and allegations in the First Amended Accusation No. 800-2015-014001, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the First Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a *prima facie* factual basis for the charges in the First Amended Accusation, and that Respondent hereby gives up his right to contest those charges. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2015-014001 shall be deemed true, correct and fully admitted by respondent for purposes of that proceeding or any other licensing proceeding involving respondent in the State of California.

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

## CONTINGENCY

11. 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 his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his 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.

12. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

13. 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. A 51494 issued to Respondent Madhava Reddy Narala, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

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

2. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing

Medical Education (CME) requirements for renewal of licensure.

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

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

3. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the Board or its designee had the program 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 program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

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

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

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

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

The monitor(s) 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 approved in advance by the Board or its designee 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.

This condition shall only apply during the first year of the probation period.

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.

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6. SUPERVISION ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising advanced practice nurses.

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.

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.

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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 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. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. 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 the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment 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 for a Respondent residing outside of 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; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

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

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

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

application shall be treated as a petition for reinstatement of a revoked certificate.

15. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

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## ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Dirk B. Paloutzian, 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: 12/04/19

MADHAVA REDDY NARALA, M.D.
*Respondent*

I have read and fully discussed with Respondent Madhava Reddy Narala, 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: 12/5/19

DIRK B. PALOUTZIAN, ESQ.
*Attorney for Respondent*

## ENDORSEMENT

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

DATED: _____

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

MICHAEL C. BRUMMEL
Deputy Attorney General
*Attorneys for Complainant*

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## ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Dirk B. Paloutzian, 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: _____

MADHAVA REDDY NARALA, M.D.
*Respondent*

I have read and fully discussed with Respondent Madhava Reddy Narala, 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: _____

DIRK B. PALOUTZIAN, ESQ.
*Attorney for Respondent*

## ENDORSEMENT

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

DATED: December 5, 2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

MICHAEL C. BRUMMEL
Deputy Attorney General
*Attorneys for Complainant*

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# Exhibit A

**First Amended Accusation No. 800-2015-014001**

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*Attorneys for Complainant*



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

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|---|---|
| In the Matter of the First Amended Accusation Against:<br><br>**Madhava Reddy Narala, M.D.**<br>**568 East Herndon, Suite 102**<br>**Fresno, CA 93720**<br><br>**Physician's and Surgeon's Certificate No. A 51494,**<br><br>Respondent. | Case No. 800-2015-014001<br><br>**FIRST AMENDED ACCUSATION** |

Complainant alleges:

**PARTIES**

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

2. On or about December 7, 1992, the Medical Board issued Physician's and Surgeon's Certificate Number A 51494 to Madhava Reddy Narala, 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 June 30, 2020, unless renewed.

## JURISDICTION

3. This First Amended 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 2234 of the Code states:

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

"(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.

". . .

"(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.

". . ."

5. 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."

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## FIRST CAUSE FOR DISCIPLINE

**(Repeated Negligent Acts)**

6. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he committed repeated acts and/or omissions constituting negligence in the care and treatment of Patient A[1], and Patient B. The circumstances are as follows:

**Patient A**

7. On or about November 21, 2012, Patient A presented to the emergency room after suffering from a grand mal seizure. Respondent, the on call physician in internal medicine at the time, was assigned to treat patient A. Patient A had not been taking his Dilantin prior to suffering a seizure. Respondent ordered labs, prescribed medications, and discharged Patient A with instructions to continue taking his Dilantin.

8. On or about September 3, 2014, Patient A presented to Respondent in his private practice office for the first time as a 55-year old male seeking an evaluation of dementia, seizure disorders, and desiring to designate Respondent as his primary care physician. Patient A was previously involved in a major automobile accident in 1978 that resulted in a major traumatic brain injury and seizure disorder. Patient A complained to Respondent of confusion, sleep disorder, and recurrent seizures. His history included a prior traumatic brain injury, encephalomalacia, and seizures. Patient A reported that he had not been taking his Dilantin, was drinking approximately 20 beers per day and smoking one pack per day. Respondent performed an examination of Patient A and diagnosed him with epilepsy, dementia, and blindness in one eye. Respondent prescribed Patient A Dilantin and folic acid. Patient A had blood work done immediately after the visit and the results were sent to Respondent's office the same day. The results revealed that Patient A's sodium levels were well below normal at 124 mMol/L, which is an indication that the patient had hyponatremia.

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[1] Patient identifiers are used herein when any reference is made to a specific patient for privacy purposes. The full name of the "patient" will be provided in response to a written request for discovery.

9. On or about September 16, 2014, Respondent's office called Patient A and told him to return to the office for a follow up appointment to discuss his lab results.

10. On or about October 7, 2014, Patient A returned to Respondent to follow up on lab results and the treatment for his seizures. The lab results revealed that Patient A's serum sodium was significantly low, which can indicate that the patient had hyponatremia. Respondent's medical records for Patient A incorrectly identify him as a new patient, even though this was his second visit to Respondent's private office. The medical records for this visit were largely cloned and/or identical to records from the September 3, 2014 visit. Patient A informed Respondent that he had stopped taking his Dilantin. Respondent did not discuss or document any discussion of Patient A's lab results or hyponatremia at this visit. Respondent continued the prescriptions for Dilantin and folic acid and made referrals for physical therapy and neurology.

11. On or about January 21, 2015, Patient A presented to Respondent complaining that his fingers would become cold and turn white, purple and red in color. Respondent diagnosed Patient A with Raynaud's Syndrome, referred him to physical therapy and neurology, and prescribed Aspirin, Norvase, Dilantin, folic acid, and ibuprofen.

12. On or about March 3, 2015, Patient A presented to Respondent. The section of the medical record for the "Chief Complaint" is identical to the information contained in prior visits. The only new documentation states that Patient A has "[p]oor functional capacity. Unable to engage in any meaningful job." Respondent diagnosed Patient A with dementia and Reynaud's Syndrome and advised him to get labs and follow up with a neurologist.

13. On or about May 13, 2015, Patient A presented to Respondent for follow up related to his seizures and to obtain refills of his medications. Respondent's documentation for Patient A's physical examination states "[t]he patient's examination is unchanged from the previous visit." Patient A was diagnosed with epilepsy and Reynaud's Syndrome and he was prescribed medications.

14. Respondent ordered lab work for Patient A during the first encounter with Patient A. Patient A completed the tests and the results were provided to Respondent's office the same day. The test results revealed that Patient A's sodium levels were extremely low and that he may have

hyponatremia. Respondent's office did not even attempt to contact Patient A to discuss the test results until after approximately 14 days had passed. Respondent did not communicate with Patient A until the next appointment in October, approximately 35 days after Respondent received the abnormal test results. Respondent failed to discuss the abnormal test results with Patient A during his appointment in October. Respondent failed to document any discussion of the abnormal test results in the medical record. Respondent failed to order additional testing for Patient A related to his abnormal test results.

**Patient B**

15. Beginning in or about 1996, continuing through August of 2016, Respondent provided care and treatment to Patient B as her primary care physician. At the outset of Patient B's treatment, Respondent would evaluate her at his office at appointments every few months. As time passed, the gaps between follow up appointments would continue to increase. At times, Respondent might allow two to eighteen months to pass between appointments with Patient B.

16. On or about September 13, 2011, Patient B presented to Respondent at eighty-five years of age for medication refills related to her high blood pressure and diabetes. Respondent prescribed her medications, noted that her abdomen was soft, and ordered a mammogram. Patient B declined flu and pneumonia vaccinations. Respondent did not document any labs or other tests related to her hypertension or diabetes, and could not remember if he performed a breast examination.

17. On or about May 21, 2012, approximately eight months later, Patient B returned to Respondent complaining of abdominal pain and suprapubic tenderness. Patient B's weight had decreased by 14 pounds; however, Respondent did not address this in the medical records. Respondent stated that he may have ordered her for a colonoscopy related to her recent weight loss, but he did not document it in the medical record. Respondent said that he could not find any documentation of the lab referral, and that typically, when he sent a patient for laboratory tests it documented in the patient medical record. Respondent's medical records for the physical examination only state that Patient B had supra pubic tenderness. Respondent diagnosed her with a urinary tract infection, but did not document any labs or other tests related to her hypertension

or diabetes. Respondent stated that he believes he sent her for a urinalysis at some point, but does not remember why.

18. On or about June 2, 2015, nearly three years and twelve days later, Patient B returned to Respondent at eighty-nine years of age for follow up care for her hyperlipidemia, hypertension and diabetes. From on or about May 22, 2012, continuing through June 1, 2015, Patient B was not evaluated by Respondent at all. Respondent continued to prescribe medications to Patient B during the three-year gap in which there were no visits or patient evaluations.

19. On or about June 15 through 22, 2016, Patient B was hospitalized related to a massive thrombophlebitis. Patient B was discharged from the hospital on warfarin and her blood pressure medications were held due to her low blood pressure. Patient B was expected to follow up with Respondent on June 24, 2016 after her release from the hospital.

20. On or about June 24, 2016, Patient B failed to show up at her scheduled appointment with Respondent. Respondent's medical records automatically populated with medication information, social history and patient history, but the records fail to contain a physical examination or any patient complaints. Respondent stated that Patient B rescheduled her appointment for July 11, 2016.

21. On or about July 11, 2016, approximately nineteen days since her hospitalization and one year and one month since her last visit, Patient B returned to Respondent at ninety years of age for follow up care and reporting that she was not taking her Coumadin. Patient B's seated blood pressure remained low at 85/60. Respondent did not document a standing blood pressure or an assessment for Patient B in the medical record. Respondent noted that Patient B was noncompliant with her Coumadin, recommended that she continue to take her medications and follow up with the Coumadin clinic.

22. On or about July 17 through 19, 2016, Patient B was hospitalized for pleuritic chest pain. Patient B was weak, not eating well and not taking her Coumadin as directed.

23. On or about July 20, 2016, Patient B presented to Respondent for follow up care related to her recent hospitalization. Respondent copied the hospital records into his chart, and noted that Patient B had blood pressure of 100/63 and that her weight had decreased to 159

pounds. Respondent did not document a plan for Patient B, or document any discussion of the reason for her recent weight loss.

24. On or about July 22 through 25, 2016, Patient B was hospitalized related to uncontrolled hypertension and acute chest pain.

25. On or about July 28, 2016, Patient B returned to Respondent for follow up related to her recent hospitalization. Respondent copied the hospital records into his electronic records for Patient B and wrote, "The patient's examination is unchanged from the previous visit." Patient B's blood pressure was 104/62, and her weight had not changed. Patient B's warfarin prescription decreased and vitamin B-12 was prescribed in addition to the Folic Acid due to a B-12 deficiency. Respondent did not document an assessment or plan in the medical records. Patient B did not return to Respondent for treatment after this visit.

**STANDARD OF CARE**

26. Communication of Lab Results to Patients. A physician should review lab results promptly and initial them to indicate that they have been reviewed. For lab results that reveal critical values or serious abnormalities, the patient may need to be called by phone the same day. In some cases, the physician may be able to discuss the lab results with the patient at the next follow-up appointment. A physician should make lab results available to patients by phone and encourage them to obtain all of their lab results.

27. Health care maintenance. Health care maintenance should be the top priority of a primary care physician. The primary care physician should take preventative measures to protect the patient including symptom and disease management, medication monitoring, appropriate laboratory testing, counseling, and treating new or acute complaints in addition to ongoing chronic patient complaints. A primary care physician must manage all of a patient's organ systems, despite strict time constraints, and patient difficulty with insurance, transportation and follow up care with specialists. An internist should endeavor to keep their patient out of the hospital, especially after recent hospitalization. An internist should evaluate their patient at appropriate intervals to evaluate their symptoms, medications, and order laboratory testing as appropriate. A well patient should be seen at least every four to six months, while a more

unstable patient taking medication or suffering from a chronic disease should be evaluated more frequently. Hypertensive patients should be evaluated more frequently as they may require medication adjustments based on their changing blood pressure results. A physician should evaluate a patient within days, or at least within a week, if the patient was recently hospitalized. If a patient misses an appointment, the physician should determine the cause for the missed appointment, arrange for care and document the missed appointment and actions taken in the medical record. A physician should set an annual wellness exam for the patient to engage in risk assessment and preventative care planning.

**DEPARTURES**

**Patient A**

28. Respondent demonstrated inadequate medical knowledge related to his care and treatment of Patient A. Respondent failed to adequately document an assessment of Patient A at each visit. Respondent demonstrated a lack of knowledge related to hyponatremia, therapeutic Dilantin levels, and eye examinations for a patient on Dilantin. Respondent failed to demonstrate adequate knowledge related to Patient A's disability evaluation. Respondent failed to obtain medical records from any of Patient A's past medical providers when he established as a patient in 2014.

29. Respondent's medical records related to the care and treatment of Patient A were disorganized and difficult to decipher. Respondent frequently cloned or copied records from prior visits in his private medical office or at the emergency room and pasted them into the records relating each visit. In the medical records for the October 7, 2014 visit, the following sections were nearly exact copies of the entries on the prior visit: chief complaint, social history, family history, medical history, basic information, history of presenting illness, review of systems, past family medical history, medical decision making, impression and plan, general questionnaire, staying health assessment, and examination. Respondent failed to document a clear assessment and plan for Patient A at each visit. Respondent failed to document phone calls made to Patient A in the medical record. Respondent failed to document in the medical records when copies of the records were produced to other providers and entities. Respondent failed to

document when he completed and delivered Patient A's disability evaluation in the medical record.

**Patient B**

30. Respondent failed to adequately manage the outpatient healthcare maintenance of Patient B. Despite regularly refilling medications for Patient B, Respondent allowed significant gaps in time ranging from months to years in between patient evaluations. Respondent did not document any explanation in the medical record for the significant gaps in examinations of Patient B, nor any plan to eliminate or reduce any future unnecessary gaps treatment.

31. Respondent rarely documented follow up plans related to the care provided to Patient B. For example, Respondent did not document when and under what circumstances Patient B was to return to him for future care. Respondent explained that he did not have any records or documentation relating to Patient B's future appointments, but "usually they call."

32. Respondent failed to engage in and document narrative assessments relating to the care and treatment of Patient B. Respondent frequently only wrote that Patient B was "noncompliant," with no additional information or explanation. Respondent's records for Patient B fail to contain orders for laboratory tests or results. When Patient B was released from the hospital, she frequently returned to Respondent for follow up care. Respondent copied the hospitalization records into his own records for Patient B, but failed to perform and document his own interval history, patient examination, assessment and plan.

33. Respondent committed repeated negligent acts in his care and treatment of Patient A and Patient B, which include, but are not limited to the following:

A. Respondent failed to adequately and accurately inform Patient A about his test results, which constitutes negligence.

B. Respondent demonstrated a lack of knowledge related to his care and treatment of Patient A, which constitutes negligence.

C. Respondent failed to conduct examinations of Patient B at appropriate intervals as a part of her ongoing health care maintenance, which constitutes negligence;

D. Respondent failed to adequately document and follow plans for Patient B as a part of her ongoing health care maintenance, which constitutes negligence;

E. Respondent failed to offer narrative assessments or document Patient B's patient management concerns as a part of her ongoing health care maintenance, which constitutes negligence;

F. Respondent failed to adequately document his medical knowledge and judgment related to the care and treatment of Patient B, which constitutes negligence.

**SECOND CAUSE FOR DISCIPLINE**

**(Failure to Maintain Adequate and Accurate Records)**

34. Respondent is subject to disciplinary action under section 2266, of the Code in that he failed to maintain adequate and accurate records in his care and treatment of Patient A and Patient B. The circumstances are set forth in paragraphs 6 through 32, which are incorporated by reference as if set forth fully herein.

**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 A 51494, issued to Madhava Reddy Narala, M.D.;

2. Revoking, suspending or denying approval of Madhava Reddy Narala, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Madhava Reddy Narala, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: February 6, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*