

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

**In the Matter of the Accusation
Against:**

John Stirling, M.D.

**Physician's and Surgeon's
Certificate No. G 88086**

Respondent.

Case No. 800-2016-021929

DECISION

The attached Stipulated Surrender of License and 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 JUL 02 2020.

IT IS SO ORDERED JUN 25 2020.

MEDICAL BOARD OF CALIFORNIA



**William Prasifka
Executive Director**

1 XAVIER BECERRA
Attorney General of California
2 JANE ZACK SIMON
Supervising Deputy Attorney General
3 LYNNE K. DOMBROWSKI
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8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2016-021929

13 **JOHN STIRLING, M.D.**

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

14 1629 Granada Avenue
San Diego, CA 92102-1435

15 Physician's and Surgeon's Certificate
16 No. G 88086

17 Respondent.

18
19 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
20 entitled proceedings that the following matters are true:

21 **PARTIES**

22 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
23 California (Board). He brings this action solely in his official capacity and is represented in this
24 matter by Xavier Becerra, Attorney General of the State of California, by Lynne K. Dombrowski,
25 Deputy Attorney General.

26 2. John Stirling, M.D. (Respondent) is representing himself in this proceeding and has
27 chosen not to exercise his right to be represented by counsel.
28

1 against Respondent. This stipulation constitutes a record of the discipline and shall become a part
2 of Respondent's license history with the Board.

3 2. Respondent shall lose all rights and privileges as a Physician and Surgeon in
4 California as of the effective date of the Board's Decision and Order.

5 3. Respondent shall cause to be delivered to the Board his pocket license and, if one was
6 issued, his wall certificate on or before the effective date of the Decision and Order.

7 4. If Respondent ever files an application for a new license or certification or a petition
8 for reinstatement of a license in the State of California, the Board shall treat it as a petition for
9 reinstatement. Respondent must comply with all the laws, regulations and procedures for
10 reinstatement of a revoked or surrendered license in effect at the time the application or petition is
11 filed, and all of the charges and allegations contained in Accusation No. 800-2016-021929 shall
12 be deemed to be true, correct and admitted by Respondent when the Board determines whether to
13 grant or deny the application or petition.

14
15 **ACCEPTANCE**

16 I have carefully read the Stipulated Surrender of License and Order. I understand the
17 stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into
18 this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and
19 agree to be bound by the Decision and Order of the Medical Board of California.

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21 DATED: 29 May 2020


22 JOHN STIRLING, M.D.
23 Respondent

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ENDORSEMENT

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

DATED: 06/09/2020

Respectfully submitted,
XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

Lynne K. Dombrowski
LYNNE K. DOMBROWSKI
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2016-021929

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Dec. 11 2018
BY SUN PANG ANALYST

8
9 **BEFORE THE**
10 **MEDICAL BOARD OF CALIFORNIA**
11 **DEPARTMENT OF CONSUMER AFFAIRS**
12 **STATE OF CALIFORNIA**

13 In the Matter of the Accusation Against:

Case No. 800-2016-021929

14 **JOHN STIRLING, M.D.**
15 1629 Granada Avenue
San Diego, CA 92102-1435

ACCUSATION

16 Physician's and Surgeon's Certificate
17 No. G 88086,

Respondent.

18
19 Complainant alleges:

20 **PARTIES**

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

24 2. On or about July 18, 2007, the Medical Board issued Physician's and Surgeon's
25 Certificate Number G 88086 to John Stirling, M.D. (Respondent). The Physician's and Surgeon's
26 Certificate was in full force and effect at all times relevant to the charges brought herein and will
27 expire on May 31, 2019, unless renewed.
28

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

2 “(g) The practice of medicine from this state into another state or country without meeting
3 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not
4 apply to this subdivision. This subdivision shall become operative upon the implementation of the
5 proposed registration program described in Section 2052.5.

6 “(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and
7 participate in an interview by the board. This subdivision shall only apply to a certificate holder
8 who is the subject of an investigation by the board.”

9 6. Section 2228 of the Code states:

10 “The authority of the board or the California Board of Podiatric Medicine to discipline a
11 licensee by placing him or her on probation includes, but is not limited to, the following:

12 “(a) Requiring the licensee to obtain additional professional training and to pass an
13 examination upon the completion of the training. The examination may be written or oral, or
14 both, and may be a practical or clinical examination, or both, at the option of the board or the
15 administrative law judge.

16 “(b) Requiring the licensee to submit to a complete diagnostic examination by one or more
17 physicians and surgeons appointed by the board. If an examination is ordered, the board shall
18 receive and consider any other report of a complete diagnostic examination given by one or more
19 physicians and surgeons of the licensee’s choice.

20 “(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including
21 requiring notice to applicable patients that the licensee is unable to perform the indicated
22 treatment, where appropriate.

23 “(d) Providing the option of alternative community service in cases other than violations
24 relating to quality of care.”

25 7. Section 2266 of the Code states: “The failure of a physician and surgeon to maintain
26 adequate and accurate records relating to the provision of services to their patients constitutes
27 unprofessional conduct.”

28

1 8. California Penal Code sections 11164 *et seq.* are known as the Child Abuse and
2 Neglect Reporting Act (“CANRA”).

3 9. California Penal Code section 11165.7, subdivision (a) (21) provides that a licensed
4 physician and surgeon is a “mandated reporter” under CANRA.

5 10. California Penal Code section 11166 states, in pertinent part:

6 “(a) Except as provided in subdivision (d), and in Section 11166.05, a mandated reporter
7 shall make a report to an agency specified in Section 11165.9 whenever the mandated reporter, in
8 his or her professional capacity or within the scope of his or her employment, has knowledge of
9 or observes a child whom the mandated reporter knows or reasonably suspects has been the
10 victim of child abuse or neglect. The mandated reporter shall make an initial report by telephone
11 to the agency immediately or as soon as is practically possible, and shall prepare and send, fax, or
12 electronically transmit a written follow-up report within 36 hours of receiving the information
13 concerning the incident. The mandated reporter may include with the report any nonprivileged
14 documentary evidence the mandated reporter possesses relating to the incident.

15 “(1) For purposes of this article, “reasonable suspicion” means that it is objectively
16 reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable
17 person in a like position, drawing, when appropriate, on his or her training and experience, to
18 suspect child abuse or neglect. “Reasonable suspicion” does not require certainty that child abuse
19 or neglect has occurred nor does it require a specific medical indication of child abuse or neglect;
20 any “reasonable suspicion” is sufficient. . . .”

21 “...”

22 “(3) A report made by a mandated reporter pursuant to this section shall be known as a
23 mandated report.

24 “...”

25 “(h) When two or more persons, who are required to report, jointly have knowledge of a
26 known or suspected instance of child abuse or neglect, and when there is agreement among them,
27 the telephone report may be made by a member of the team selected by mutual agreement and a
28 single report may be made and signed by the selected member of the reporting team. Any

1 member who has knowledge that the member designated to report has failed to do so shall
2 thereafter make the report.

3 “(i)(1) The reporting duties under this section are individual, and no supervisor or
4 administrator may impede or inhibit the reporting duties, and no person making a report shall be
5 subject to any sanction for making the report. . . .”

6 **FIRST CAUSE FOR DISCIPLINE**

7 **(Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Acts; Failure to**
8 **Comply with CANRA Mandatory Reporting)**

9 11. Respondent John Stirling, M.D. is subject to disciplinary action for unprofessional
10 conduct through gross negligence and/or repeated negligent acts under Business and Professions
11 Code section 2234, subdivisions (b) and/or (c), and/or through failure to file a mandatory report
12 under California Penal Code section 11166, as described herein.

13 12. On or about July 2, 2015, Patient A, a boy of about two-years-of age, was seen at the
14 Emergency Department (“ED”) of O’Connor Hospital (“O’Connor”) in San Jose. The patient
15 complained of right elbow pain and was diagnosed with a right supracondylar fracture and buckle
16 fracture of the right distal radius. The examination of the left upper extremity was normal. The
17 parents reported that Patient A fell backward while running on a tile floor. The patient’s right
18 arm was splinted and follow-up was arranged with orthopedics.

19 13. The next day, on July 3, 2015, Patient A returned to the ED at O’Connor with a
20 complaint of left arm pain and swelling of the left upper extremity. The parents said that they
21 were not aware of any new falls and that the left arm swelling had developed about 20 minutes
22 before they arrived at the hospital. The diagnosis was a left supracondylar fracture. A skeletal
23 survey x-ray (a 10-view battered child series of x-rays of the chest, legs, skull) was obtained.

24 14. Patient A was transported by ambulance from O’Connor to Santa Clara Valley
25 Medical Center (“SCVMC”) for pediatric orthopedic care. It was reported that physicians at
26 O’Connor were also concerned about the possibility of non-accidental trauma (“NAT”).

27 15. On or about July 3, 2015 at about midnight, Respondent’s SCAN team partner, who
28 was on-call as the child abuse expert, received a call from a pediatric physician at SCVMC who

1 examined Patient A and reviewed the case for orthopedic care and for further assessment of the
2 possibility of a non-accidental trauma. The other SCAN team physician opined that Patient A's
3 injuries were not likely to be non-accidental trauma, that the described mechanism of fall was
4 consistent with the injuries, and that no report needed to be filed with Child Protective Services
5 ("CPS").

6 16. Patient A was admitted overnight to the hospital for surgical repair. Repeated x-rays
7 of the bilateral upper extremities were ordered at SCVMC.

8 17. Prior to Patient A's discharge on July 4, 2015, a SCVMC pediatric hospitalist
9 reviewed the patient's history and contacted Respondent, who was the on-call child abuse expert
10 at that time, for a telephone consultation about possible NAT. Respondent concluded that Patient
11 A's injuries were most likely accidental trauma and that a CPS report was not recommended. The
12 patient was discharged home with orthopedic follow-up scheduled. No report was filed with
13 Child Protective Services. Respondent did not document this consultation.

14 18. On or about July 7, 2015, a SCVMC physician was notified by a radiologist that
15 Patient A's skeletal survey x-rays from O'Connor showed a "late subacute fracture deformity in
16 the distal metaphysis of the left femur." The radiologist noted that: "Combination of acute and
17 late sub-acute or chronic fractures in the pediatric skeleton suspicious for non-accidental trauma.
18 Recommend clinical correlation."

19 19. On or about July 7, 2015, Respondent received an e-mail from a SCVMC physician
20 regarding concerns about the multiple fractures and about the newly reported femur fracture. The
21 SCVMC ED physician also called and spoke with Respondent, who was the on-call child abuse
22 expert, about Patient A. Respondent's opinion was that, although the femur fracture was not as
23 characteristic an injury for the fall described, he still had an overall low index of suspicion for
24 non-accidental trauma and did not feel that a CPS report was warranted. Respondent
25 recommended that lab studies and screenings be done to test the patient's bone fragility. The labs
26 were ordered and drawn and the results did not raise any concerns.

27 20. On or about November 16, 2015, the Chairman of the Pediatrics Department at
28 SCVMC contacted the other SCAN team physician about concerns raised by orthopedic

1 physicians about Patient A's case, the combination of known treated injuries, and the possibility
2 of NAT, and asked that the physician perform a chart review.

3 21. On or about November 17, 2015, the other SCAN team physician reported, after her
4 chart review, that it was her opinion that a report to Child Protective Services ("CPS") was
5 warranted. Respondent discussed the case by email with his SCAN team partner and it was
6 agreed that Respondent would file the CPS report. Respondent stated that he would "follow up
7 tomorrow" with the report to CPS about Patient A.

8 22. On or about November 17, 2015, the Chairman of the SCVMC Pediatrics Department
9 was informed that Respondent would report Patient A's case to CPS.

10 23. On or about December 22, 2015, Respondent was contacted by his SCAN team
11 partner because a CPS report was not filed on Patient A. Respondent admitted that he had not
12 filed a CPS report.

13 24. On or about December 24, 2015, Respondent posted a note in Patient A's chart in
14 which he stated that "there was a low expectation of non-accidental trauma in this case." He did
15 not mention the occult femur fracture, which had raised concerns and had prompted subsequent
16 review of the case.

17 25. Respondent never filed a report with Child Protective Services about suspected child
18 abuse of Patient A.

19 26. On or about January 16, 2016, Patient A was found dead at home as the result of a
20 suspected homicide with evidence of physical and sexual abuse.

21 27. Respondent is guilty of unprofessional conduct through gross negligence and/or
22 repeated negligent acts, under Business and Professions Code sections 2234, subdivisions (b)
23 and/or (c), as follows:

- 24 a. Respondent failed to make a mandatory report to the appropriate agency under
25 California Penal Code section 11166 when he had, or should have had, a reasonable
26 suspicion to suspect child abuse or neglect.
- 27 b. Respondent failed to file a CPS report with regard to Patient A after he agreed to file
28 the report for the SCAN team.

- 1 c. When notified of his failure to file a CPS report, Respondent did not file the report.
2 d. Respondent failed to adequately document his communications and/or consultations
3 regarding Patient A.
4

5 **SECOND CAUSE FOR DISCIPLINE**

6 **(Unprofessional Conduct: Failure to Maintain Adequate and Accurate Records)**

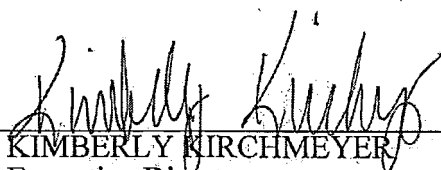
7 28. Respondent John Stirling, M.D. is subject to disciplinary action for unprofessional
8 conduct under section 2266 for failing to maintain adequate and accurate records with regard to
9 Patient A. Paragraphs 11 through 27 are incorporated herein by reference as if fully set forth.
10

11 **PRAYER**

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

- 14 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 88086,
15 issued to John Stirling, M.D.;
- 16 2. Revoking, suspending or denying approval of John Stirling, M.D.'s authority to
17 supervise physician assistants and advanced practice nurses;
- 18 3. Ordering John Stirling, M.D., if placed on probation, to pay the Board the costs of
19 probation monitoring; and
- 20 4. Taking such other and further action as deemed necessary and proper.
21

22
23 DATED: December 11, 2018


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

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