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

In the Matter of the Accusation Against:	
John Stirling, M.D.	**Case No. 800-2016-021929**
Physician's and Surgeon's Certificate No. G 88086	
Respondent.	

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 0 2 2020 .

IT IS SO ORDERED JUN 2 5 2020 .

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

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

In the Matter of the Accusation Against: **JOHN STIRLING, M.D.** 1629 Granada Avenue San Diego, CA 92102-1435 Physician's and Surgeon's Certificate No. G 88086 Respondent.	Case No. 800-2016-021929 **STIPULATED SURRENDER OF LICENSE AND 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. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brings this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Lynne K. Dombrowski, Deputy Attorney General.

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

3. On or about July 18, 2007, the Board issued Physician's and Surgeon's Certificate No. G 88086 to John Stirling, 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. 800-2016-021929 and will expire on May 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2016-021929 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on December 11, 2018. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2016-021929 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in Accusation No. 800-2016-021929. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

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

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

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2016-021929, 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 Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

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

CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent. 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 Surrender 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 Surrender of License and 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 Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 88086, issued to Respondent John Stirling, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline

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

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

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

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

ACCEPTANCE

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

DATED: 29 May 2020

JOHN STIRLING, M.D.
Respondent

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

In the Matter of the Accusation Against: **JOHN STIRLING, M.D.** 1629 Granada Avenue San Diego, CA 92102-1435 Physician's and Surgeon's Certificate No. G 88086, Respondent.	Case No. 800-2016-021929 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this 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 July 18, 2007, the Medical Board issued Physician's and Surgeon's Certificate Number G 88086 to John Stirling, 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 May 31, 2019, unless renewed.

3. At all times alleged herein, Respondent was Board-certified in Pediatrics and in Child Abuse Pediatrics. Respondent was one of two physicians designated as a child abuse expert at Santa Clara Valley Medical Center (SCVMC) and was a member of the Suspected Child Abuse and Neglect (SCAN) team. Respondent was also the Director of the SCVMC Center for Child Protection.

JURISDICTION

4. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. 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.

"(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 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.

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

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

6. Section 2228 of the Code states:

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

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

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

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

"(d) Providing the option of alternative community service in cases other than violations relating to quality of care.@

7. 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."

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

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

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

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

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

". . ."

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

". . ."

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

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

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

FIRST CAUSE FOR DISCIPLINE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Respondent failed to make a mandatory report to the appropriate agency under California Penal Code section 11166 when he had, or should have had, a reasonable suspicion to suspect child abuse or neglect.

b. Respondent failed to file a CPS report with regard to Patient A after he agreed to file the report for the SCAN team.

c. When notified of his failure to file a CPS report, Respondent did not file the report.

d. Respondent failed to adequately document his communications and/or consultations regarding Patient A.

SECOND CAUSE FOR DISCIPLINE

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

28. Respondent John Stirling, M.D. is subject to disciplinary action for unprofessional conduct under section 2266 for failing to maintain adequate and accurate records with regard to Patient A. Paragraphs 11 through 27 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 G 88086, issued to John Stirling, M.D.;

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

3. Ordering John Stirling, 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: December 11, 2018

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

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