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

In the Matter of the Accusation Against: Jonathan Emeka Akanno, M.D. Physician's & Surgeon's Certificate No. A 61907 Respondent.	Case No. 800-2016-020738

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 29, 2022.

IT IS SO ORDERED: August 30, 2022.

MEDICAL BOARD OF CALIFORNIA

Laurie Rose Lubiano, J.D., Chair
Panel A

Polsinelli LLP
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BEFORE THE

MEDICAL BOARD OF CALIFORNIA

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against: Jonathan Emeka Akanno, M.D. 10303 Mersham Hill Drive Bakersfield, CA 93301 Physician's and Surgeon's Certificate No. A 61907, Respondent.	Case No. 800-2016-020738 OAH No. 2019030652 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER** Date: June 13, 2022 Time: 9:00 A.M. Dept.: Office of Administrative Hearings, Los Angeles

Polsinelli LLP
2049 Century Park East, Suite 2900
Los Angeles, CA 90067
(310) 556-1801

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

PARTIES

1. William Prafiska (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Erin Muellenberg, Esq. of Polsinelli LLP.

2. Respondent Jonathan Emeka Akanno, M.D. (Respondent) is represented in this proceeding by attorney John D. Harwell, Esq., whose address is: 225 27th Street, Manhattan Beach, CA 90266; and attorney Mandy Jeffcoach, Esq., whose address is: Whitney Thompson & Jeffcoach, 970 West Alluvial Avenue, Fresno, CA 93711.

3. On or about April 4, 1997, the Board issued Physician's and Surgeon's Certificate No. A 61097 to 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. 800-2016-020738, and will expire on March 31, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2016-020738 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 March 1, 2019. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A true and correct copy of Accusation No. 800-2016-020738 is attached hereto 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 Accusation No. 800-2016-020738. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. 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 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.

8. Having the benefit of counsel, 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 Accusation No. 800-2016-020738.

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 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 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 opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED that the Respondent, Jonathan Emeka Akanno, M.D., Physician's and Surgeon's Certificate No. A 61097, shall be and hereby is publicly reprimanded pursuant to California Business and Professions Code, section 2234, subdivision (c) and section 2266. This Public Reprimand, which is issued in connection with Respondent's conduct as set forth in Accusation No. 800-2016-020738, is as follows: You demonstrated unprofessional conduct, pursuant to California Business and Professions Code, section 2234, subdivision (c) and section 2266 when you deviated from the standard of care and treatment for five patients and failed to maintain adequate and accurate records relating to the provision of services to those same patients. Consequently, the Board issues this Public Reprimand.

B. IT IS FURTHER ORDERED:

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 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 this 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, John D. Harwell, Esq. and/or Mandy Jeffcoach, Esq. I understand this 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: May 15, 2022

By: JONATHAN EMEKA AKANNO, M.D.
Respondent

I have read and fully discussed with Respondent, Jonathan Emeka Akanno, 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: May 15, 2022

By: MANDY JEFFCOACH, 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: April 25, 2022.

POLSINELLI LLP

By: ERIN MUELLENBERG

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO March 1 2019
BY D. Richards ANALYST

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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: **Jonathan Emeka Akanno, M.D.** **PO BOX 21765** **Bakersfield, CA 93390-1765** **Physician's and Surgeon's Certificate No. A 61907,** Respondent.	Case No. 800-2016-020738 **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 April 4, 1997, the Medical Board issued Physician's and Surgeon's Certificate No. A 61907 to Jonathan Emeka Akanno, M.D. (Respondent). The Physician's and

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Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2021, 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 unless otherwise indicated.

4. Section 2227 of the Code states:

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

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

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

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

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

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

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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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 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."

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

7. Respondent has subjected his Physician's and Surgeon's License No. A 61907 to disciplinary action, as defined by section 2234, subdivision (c), in that he engaged in repeated negligent acts in the care and treatment of Patient A, Patient B, Patient C, Patient D, and Patient E. The circumstances are as follows:

8. At all times relevant to this pleading, Respondent worked as a physician for the California Correctional Health Services treating patients who were inmates at the California Department of Corrections and Rehabilitation. Respondent treated patients at a Yard Clinic or a Triage and Treatment Area (TTA) within the prison. Patients treated at the yard clinic were able to request a scheduled appointment with a physician, or drop in if an appointment was available. Patients treated at the TTA were processed in a manner similar to an urgent care clinic. The TTA was open 24-hours a day and served critical care patients on an as needed basis.

Patient A[1]

9. On or about November 16, 2015, Patient A presented to Respondent complaining of occasional pains that were causing him difficulty in carrying out his daily activities. Patient A's history included a discectomy in 2010, and a diagnosis of degenerative joint disease of the Lumbar-Sacral spine. Patient A was currently prescribed Morphine Extended Release 30 mg, twice daily. Respondent documented that Patient A's neurological assessment was positive for lower left weakness in his extremities. Respondent refilled Patient A's prescription for Morphine for 90 days, prescribed the anti-convulsant medication Oxcarbazepine, and recommended a return visit in three months.

[1] Patients are referred to by letter to protect their privacy.

10. Respondent did not document a physical assessment relating to Patient A's presenting complaint of pain. Respondent failed to document key physical findings relating to the presence or absence of reflexes including whether the weakness was distal or proximal, whether the weakness was mild, moderate or severe, or whether there were other neurological deficits that required additional examination. Respondent failed to document a treatment plan or any objectives related to the continued prescriptions of opiates. Respondent failed to document a treatment plan, or consider any additional referrals or evaluations for Patient A's complaint of pain. In an interview with investigators, Respondent admitted that he did not document any additional neurologic findings. Respondent stated that the TTA was not staffed adequately and time was a big problem.

Patient B

11. On or about October 6, 2015, Patient B presented to Respondent with a history of a right knee ACL reconstruction that occurred on September 25, 2015. Patient B presented in a long leg cast and had no complaints.

12. On or about November 23, 2015, Patient B presented to Respondent requesting help in returning his wheelchair. Respondent discontinued the order for a wheelchair, and ordered crutches and pain medication. Respondent did not examine Patient B's knee, or document what level of weight bearing Patient B should perform. Patient B had received treatment in physical therapy that documented his progress and weight bearing ability, but Respondent failed to reference it in his physical assessment or document that he reviewed the physical therapy records. In an interview with investigators, Respondent admitted that he did not examine Patient B's knee.

Patient C

13. On or about October 29, 2015, Patient C presented to Respondent with back pain resulting from a lumbar compression fracture.

14. On or about November 19, 2015, Patient C presented to Respondent at the Yard Clinic for an appointment to discuss a special diet or medication to help with his Irritable Bowel Syndrome (IBS). Patient C presented with a history that included a lumbar compression fracture and IBS. Respondent performed and documented a heart and lung examination, but did not

perform an examination of Patient C's abdomen. Respondent did not ask questions of Patient C to elicit additional information related to his complaint of IBS. Respondent failed to perform and/or document an assessment and plan related to Patient C's history of IBS. In an interview with investigators, Respondent admitted that he did not perform an abdominal examination of Patient C.

15. On or about January 19, 2016, Patient C presented to Respondent complaining of continued back pain. Respondent documented Patient C's history of a lumbar compression facture and characterized it as stable. Respondent failed to perform and/or document an adequate musculoskeletal examination related to Patient C's complaint of back pain. Respondent documented that a musculoskeletal and neurological examination was performed, but only wrote that it was within normal limits without adding any specific findings or observations.

Patient D

16. On or about November 18, 2015, Patient D presented to Respondent complaining of blurry vision and continued left hip pain. Patient D had a history of hypertension, diabetes, and dyslipidemia. Respondent documented that the eye examination and physical examination were within normal limits. Despite Patient D's history of diabetes and complaint of blurred vision, Respondent failed to document adequate specific findings of the eye examination. In an interview with investigators, Respondent stated that he recalls examining Patient D's eyes, but it "wasn't the best documentation."

17. On or about January 25, 2016, Patient D returned to Respondent complaining of increasing left hip pain. Rather than documenting specific findings of the musculoskeletal examination, Respondent only wrote that the results were within normal limits.

Patient E

18. On or about November 9, 2015, Patient E presented to Respondent for a follow up visit related to a prior biopsy of an eyebrow lesion from October 30, 2015, and requesting pain medication for chronic pain in his right shoulder. Respondent did not have the biopsy results available at this visit. Respondent prescribed him ibuprofen for his pain and advised him to return for his biopsy results in the future. Respondent did not contact the pathology lab to obtain

the biopsy results, or direct another staff member to do so on his behalf. Respondent failed to document Patient E's pain symptoms or conduct a physical examination of his shoulder. In an interview with investigators, Respondent stated that he probably should have examined Patient E's shoulder, but "time was probably of essence."

19. On or about November 19, 2015, Patient E returned to Respondent to obtain the results of his prior biopsy. Patient E's biopsy results were still unavailable. Respondent stated that he called the specialty clinic, and directed his nurse to call the specialty clinic to follow up on the missing biopsy results, but failed to document this in the medical records. In an interview with investigators, Respondent admitted that he did not attempt to call the pathology lab to obtain the biopsy results.

STANDARD OF CARE

20. The standard of care is to perform an adequate history and physical assessment based on a patient's complaint. A physician should conduct an adequate history and physical, and document an assessment and plan of action to address the patient's complaint.

21. The standard of care for pain management requires that a physician and surgeon perform an adequate history and physical examination. A physician should document a treatment plan that identifies specific objectives, by which the plan can assess pain relief, improved physical or psychosocial function. A physician should evaluate progress towards treatment objectives when determining whether to continue treatment by opiate medications. The treating physician should consider referring the patient for additional evaluation and treatment as indicated, in order to further the objectives of the treatment plan.

22. The standard of care in treating a patient after an ACL reconstruction requires that the physician perform a knee examination. The physician should know when and how the patient should begin ambulation after surgery. The physician should review and consider the recommendations made by the surgeon of record, and adhere to the physical therapy recommendations.

23. The standard of care after a biopsy requires the physician to report the biopsy results to the patient in a timely manner. If the biopsy results are unavailable, the physician should

follow up on the missing results and document efforts to obtain the results in the patient's medical record.

DEPARTURES

Patient A

24. Respondent failed to perform and/or document an adequate history and physical assessment relating to Patient A's complaint, which constitutes a departure from the standard of care.

25. Respondent failed to perform and/or document an adequate pain management history and physical assessment of Patient A, which constitutes a departure from the standard of care.

Patient B

26. Respondent failed to perform and/or document an adequate knee examination of Patient B, which constitutes a departure from the standard of care.

27. Respondent lacked knowledge and/or failed to document when and to what extent Patient B should begin bearing weight on his knee after ACL reconstruction surgery, which constitutes a departure from the standard of care.

Patient C

28. Respondent failed to perform and/or document an adequate history and physical examination related to Patient C's IBS, which constitutes a departure from the standard of care.

29. Respondent failed to document an adequate history and physical examination related to Patient C's complaint of back pain, which constitutes a departure from the standard of care.

Patient D

30. Respondent failed to adequately document the physical findings of Patient D's eye exam, which constitutes a departure from the standard of care.

31. Respondent failed to adequately document the physical findings of Patient D's musculoskeletal examination, which constitutes a departure from the standard of care.

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Patient E

32. Respondent failed to provide Patient E with the results of his biopsy in a timely manner, which constitutes a departure from the standard of care.

33. Respondent failed to perform a history and physical examination of Patient E's complaint of shoulder pain, which constitutes a departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

34. Respondent has subjected his Physician's and Surgeon's License No. A 61907 to disciplinary action, as defined by section 2266, in that he failed to maintain adequate and accurate records relating to the provision of services to Patient A, Patient B, Patient C, Patient D, and Patient E. The circumstances are more particularly alleged in paragraphs 8 through 19, which are hereby incorporated by reference and realleged as if fully set forth 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 61907, issued to Jonathan Emeka Akanno, M.D.;

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

3. Ordering Jonathan Emeka Akanno, 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: March 1, 2019

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