

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

In the Matter of the Accusation Against:

Lonna Larsh, M.D.

Physician's & Surgeon's
Certificate No. G 75442

Respondent.

Case No. 800-2019-054265

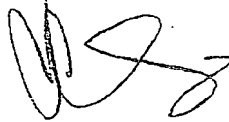
DECISION

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 December 2, 2022.

IT IS SO ORDERED: November 3, 2022.

MEDICAL BOARD OF CALIFORNIA



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

1 ROB BONTA
Attorney General of California
2 MARY CAIN-SIMON
Supervising Deputy Attorney General
3 DAVID CARR
Deputy Attorney General
4 State Bar No. 131672
455 Golden Gate Avenue, Suite 11000
5 San Francisco, CA 94102-7004
Telephone: (415) 510-3380
6 Facsimile: (415) 703-5480
Attorneys for Complainant
7

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

12 In the Matter of the Accusation Against:
13 **LONNA LARSH, M.D.**
709 Frederick Street
14 Santa Cruz, CA 95062-2204
15 **Physician's and Surgeon's**
Certificate No. G 75442
16
17 Respondent.

Case No. 800-2019-054265

OAH No. 2022030442

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

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

22 **PARTIES**

23 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
24 California (Board). He brought this action solely in his official capacity and is represented in this
25 matter by Rob Bonta, Attorney General of the State of California, by David Carr, Deputy
26 Attorney General.

27 2. Lonna Larsh, M.D., is represented in this proceeding by attorney Sarvnaz R. Mackin,
28 of Nelson Hardiman, whose address is: 1100 Glendon Ave., 14th Floor, Los Angeles, CA 90024.

1 **DISCIPLINARY ORDER**

2 **A. PUBLIC REPRIMAND**

3 IT IS HEREBY ORDERED that Respondent Lonna Larsh, M.D., Physician's and
4 Surgeon's Certificate No. G 75442, shall be and hereby is publically reprimanded pursuant to
5 Business and Professions Code section 2227. This Public Reprimand, which is issued in
6 connection with Respondent's conduct as set forth in Accusation No. 800-2019-054265, is as
7 follows: Pursuant to Business and Professions Code sections 2234 and 2234, subdivision (c), you
8 demonstrated unprofessional conduct through repeated negligent acts in the treatment of Patient
9 One by unduly relying on a physical examination and initial assessment of the patient performed
10 by a non-physician and failing to document an adequate clinical basis for Patient One's
11 subsequent treatment. Consequently, the Board issues this Public Reprimand.

12 **B. IT IS FURTHER ORDERED:**

13 1. **PROFESSIONALISM COURSE.** Within 60 calendar days of the effective date of
14 this Decision, Respondent shall enroll in a professionalism course that meets the requirements of
15 Title 16, California Code of Regulations section 1358.1. Respondent shall participate in and
16 successfully complete the program. Respondent shall provide the approved course provider with
17 any information and documents that the approved course provider may deem pertinent.
18 Respondent shall participate in and successfully complete the classroom component of the course
19 not later than six (6) months after Respondent's initial enrollment, and the longitudinal
20 component of the program not later than the time specified by the program, but not later than one
21 (1) year after attending the classroom component. The professionalism course shall be at
22 Respondent's expense and shall be in addition to the Continuing Medical Education (CME)
23 requirements for renewal of licensure.

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

1 Respondent shall submit a certification of successful completion to the Board or its
2 designee not later than 15 calendar days after successfully completing the course, or not later than
3 15 calendar days after the effective date of the Decision, whichever is later.

4 2. ADDITIONAL CONTINUING MEDICAL EDUCATION Within 60 calendar days
5 of the effective date of this Decision Respondent shall submit to the Board or its designee for its
6 prior approval educational program(s) or course(s) which shall include medical record-keeping
7 and initial patient assessment and which shall not less than 25 hours above and in addition to the
8 25 hours of CME required for license renewal. The educational program(s) or course(s) shall be
9 at Respondent's expense. Following the completion of each course, the Board or its designee
10 may administer an examination to test Respondent's knowledge of the course.

11 3. INVESTIGATION AND ENFORCEMENT COSTS RECOVERY Respondent is
12 hereby ordered to reimburse the Board for its costs of investigation and enforcement in this case
13 incurred after January 1, 2022, in the amount of \$3,091 (Three Thousand, Ninety-One Dollars).
14 Costs shall be payable to the Medical Board of California. Any requests for a payment plan shall
15 be submitted in writing by Respondent to the Board. The filing of bankruptcy by Respondent
16 shall not relieve her of the responsibility to repay investigation and enforcement costs.

17 4. FUTURE ADMISSIONS CLAUSE If Respondent should ever apply or reapply for
18 a new license or certification, or petition for reinstatement of a license, by any other health care
19 licensing action agency in the State of California, all of the charges and allegations contained in
20 Accusation No. 800-2019-054265 shall be deemed to be true, correct, and admitted by
21 Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or
22 restrict a license.

23 24 ACCEPTANCE

25 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
26 discussed it with my attorney, Sarvnaz R. Mackin. I understand the stipulation and the effect it
27 will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and
28

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

3
4 DATED: 5/17/2021 
5 LONNA LARSH, M.D.
6 Respondent

7
8 I have read and fully discussed with Respondent Lonna Larsh, M.D. the terms and
9 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.
10 I approve its form and content.

11
12 DATED: 5/17/22 
13 SARVNAZ R. MACKIN
14 Attorney for Respondent

15
16 **ENDORSEMENT**

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

19 DATED: May 19, 2022
20 ROB BONTA
21 Attorney General of California
22 MARY CAIN-SIMON
23 Supervising Deputy Attorney General

24 
25 DAVID CARR
26 Deputy Attorney General
27 Attorneys for Complainant

28 SF2021401516

EXHIBIT A
ACCUSATION NO. 800-2019-054265

1 ROB BONTA
Attorney General of California
2 MARY CAIN-SIMON
Supervising Deputy Attorney General
3 DAVID CARR
Deputy Attorney General
4 State Bar No. 131672
455 Golden Gate Avenue, Suite 11000
5 San Francisco, CA 94102-7004
Telephone: (415) 510-3380
6 Facsimile: (415) 703-5480
Attorneys for Complainant
7

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

12 In the Matter of the Accusation Against:

Case No. 800-2019-054265

13 **LONNA LARSH, M.D.**
14 **709 Frederick St.**
Santa Cruz, CA 95062-2204

A C C U S A T I O N

15 **Physician's and Surgeon's Certificate**
16 **No. G 75442,**

17 Respondent.

18
19
20 **PARTIES**

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

24 2. On October 27, 1992, the Board issued Physician's and Surgeon's Certificate Number
25 G 75442 to Lonna Larsh, M.D. (Respondent). The Physician's and Surgeon's Certificate was in
26 full force and effect at all times relevant to the allegations brought herein and will expire on
27 September 30, 2022, unless renewed.

28 ///

1 JURISDICTION

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

5 4. Section 2001.1 of the Code makes public protection the Board's highest priority.

6 5. Section 2227 of the Code states:

7 (a) A licensee whose matter has been heard by an administrative law judge of
8 the Medical Quality Hearing Panel as designated in Section 11371 of the Government
9 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:

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

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

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

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

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

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

26 6. Section 2234 of the Code, states:

27 The board shall take action against any licensee who is charged with
28 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 (1) An initial negligent diagnosis followed by an act or omission medically
2 appropriate for that negligent diagnosis of the patient shall constitute a single
3 negligent act.

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

9 (d) Incompetence.

10 (e) The commission of any act involving dishonesty or corruption that is
11 substantially related to the qualifications, functions, or duties of a physician and
12 surgeon.

13 (f) Any action or conduct that would have warranted the denial of a certificate.

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

17 7. Section 2266 of the Code states:

18 "The failure of a physician and surgeon to maintain adequate and accurate records
19 relating to the provision of services to their patients constitutes unprofessional conduct."

20 8. Effective beginning January 1, 2022, section 125.3 of the Code provides that the
21 Board may request the administrative law judge to direct a licensee found to have committed a
22 violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the
23 investigation and enforcement of the case, with failure of the licensee to comply subjecting the
24 license to not being renewed or reinstated. If a case settles, recovery of investigation and
25 enforcement costs may be included in a stipulated settlement.

26 9. The events described herein occurred in Santa Cruz County, California.

27 FIRST CAUSE FOR DISCIPLINE

28 (Gross Negligence/Repeated Negligent Acts)

10. Respondent Lonna Larsh, M.D., is subject to disciplinary action under Code sections
2234(b) and/or 2234(c), in that her care and treatment of Patient One¹ included departures
from the standard of care constituting gross negligence and/or repeated negligent acts.

¹ The patient is referred to herein as Patient One to preserve patient confidentiality. The
patient's full name will be provided to Respondent upon request.

1 11. In response to online advertising, Patient One visited Natural Foundations² clinic on
2 January 16, 2018, to inquire about laser treatment for weight loss. After meeting with a non-
3 physician staff member or the chiropractor co-owner of the clinic, Patient One purchased a
4 treatment package of laser treatments and hormone replacement for weight loss. The Natural
5 Foundations medical records for Patient One contain an undated, one-page medical questionnaire
6 but no record of a physical examination of the patient or a focused medical history conducted by
7 anyone at any time. A one-page "V-Shape Informed Consent Form" for "radio-frequency
8 device" treatment of skin wrinkles bears Patient One's signature, without an accompanying date,
9 and Respondent's signature with an accompanying date of May 11, 2018. The medical record
10 documents a series of "V-Shape" treatments, administered by a registered nurse, beginning on
11 January 18, 2018 and concluding on March 15, 2018.

12 12. On January 23, 2018, at his second visit to Natural Foundations for radio frequency
13 treatment for skin wrinkles, Patient One signed a four-page "Informed Consent for Treatment For
14 Body by Laser." The form states that the patient's signature was witnessed on January 23, 2018
15 by the registered nurse employed at Natural Foundation, and by her appended signature
16 Respondent attested, on March 9, 2018, that "the patient has been adequately informed and has
17 consented" to the laser treatments that Patient One had begun receiving on February 1, 2018.

18 13. On March 2, 2018, Respondent met with Patient One for the first time, just before
19 inserting ten 200 mg. pellets of compounded testosterone surgically into Patient One. There is no
20 operative report of this procedure contained in the certified medical records from Natural
21 Foundation. Just one day prior to her April 16, 2021 interview with Board investigators about
22 this case, Respondent emailed Board investigators an unsigned, two-page document that
23 Respondent claimed was the operative report of Respondent's March 2, 2018, testosterone pellet
24 implant procedure on Patient One. In the email bearing this document, Respondent informed the
25 investigator that: "The records that you received from the clinic I was working with at the time of
26 that insertion did not include the procedure note. I have been able to get a copy of that note from
27

28 ² In January of 2018, Natural Foundations was a medical clinic co-owned by Respondent
and Susan White, a California-licensed chiropractor.

1 the electronic medical record system that we used at that time.” The document’s brief narrative,
2 evidently authored by Respondent, states that Respondent discussed the treatment options with
3 the patient “and he chose the pellets and I fully informed him of the risks and possible
4 complications of pellet hormonal replacement therapy and insertion. He signed the informed
5 consent and waiver.” The is a single page, pre-printed “Consent for Hormone Implantation”
6 bearing Patient One’s signature in the medical record, but it refers only to the risks of local
7 anesthesia, bleeding, and/or infection.

8 14. The two page operative report Respondent provided to Board investigators on April
9 15, 2021 also makes a one-line diagnosis of Patient One: “He has hormonal deficit as the primary
10 cause of his problems.” All documentation within the medical records for Patient One indicate
11 that he was being treated solely for weight loss and the cosmetic skin complications therefrom.
12 The only laboratory test results of Patient One’s testosterone levels in the medical records show a
13 post-procedure reading—from a blood sample taken on April 4, 2018--of 923 ng/dL; the normal
14 reading for this test is 250-1100 ng/dL³. There is a handwritten notation of “329” and an arrow
15 pointing toward the higher “923” figure, but no other reference. In her two-page procedure note,
16 Respondent recorded Patient One’s testosterone level as 329. That handwritten number of “329,”
17 with no supporting lab reports anywhere in Patient One’s record, is also within the normal range
18 as established in the later laboratory report of April 4, 2018. There is no indication that
19 Respondent conducted any physical examination or obtained any history from Patient One
20 sufficient to form a rational clinical basis for treatment of testosterone deficiency. In her
21 interview with Board investigators, Respondent stated that Patient One had agreed to testosterone
22 pellet insertion after talking with chiropractor Susan White and Respondent had not discussed that
23 treatment with Patient One prior to the day of the pellet insertion: “I didn’t speak with him until
24 after he had already signed up for this.”

25 15. Respondent has subjected her license to disciplinary action for unprofessional
26 conduct in that her failure to clinically evaluate Patient One by obtaining an adequate physical
27 examination and history prior to subjecting Patient One to the surgical implantation procedure

28 ³ Ng/dL is standard medical notation for “nanograms per deciliter.”

1 was a departure from the standard of care constituting gross negligence in violation of section
2 2234(b) of the Code or, in conjunction with the other departures from the standard of care
3 alleged herein, repeated negligent acts in violation of section 2234(c) of the Code.

4 **SECOND CAUSE FOR DISCIPLINE**

5 **(Gross Negligence/Repeated Negligent Acts)**

6 16. The allegations of paragraphs 11-14 above are incorporated by reference as if set out
7 in full. Respondent is subject to disciplinary action under sections 2234(b) and/or 2234(c) of the
8 Code, in that her treatment of Patient One with surgically implanted testosterone pellets without
9 a documented clinical basis sufficient to establish a hormonal deficit was an extreme departure
10 from the standard of care constituting gross negligence or, in conjunction with the other negligent
11 act alleged herein, repeated negligent acts.

12 **THIRD CAUSE FOR DISCIPLINE**

13 **(Repeated Negligent Acts)**

14 17. The allegations of paragraphs 11-14 above are incorporated by reference as if
15 set out in full. Respondent is subject to disciplinary action under sections 2234(c) of the Code, in
16 that her failure to adequately inform Patient One of the risks, benefits, and alternatives to the
17 surgical procedure and obtain knowing consent for that procedure was a departure from the
18 standard of care that, in conjunction with the other negligent acts alleged herein, constitutes
19 repeated negligent acts.

20 **FOURTH CAUSE FOR DISCIPLINE**

21 **(Failure to Maintain Accurate and Accurate Medical Records)**


22 18. The allegations of paragraphs 11-14 above are incorporated by reference as if set out
23 in full. Respondent is subject to disciplinary action under section 2266 of the Code in that she
24 failed to maintain adequate and accurate records relating to her care and treatment of Patient One.

25
26 **PRAYER**

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

- 1 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 75442,
- 2 issued to Respondent Lonna Larsh, M.D.;
- 3 2. Revoking, suspending or denying approval of Respondent Lonna Larsh, M.D.'s
- 4 authority to supervise physician assistants and advanced practice nurses;
- 5 3. Ordering Respondent Lonna Larsh, M.D., to pay the Board the reasonable costs of
- 6 investigation and prosecution of this case incurred after January 1, 2022, and, if placed on
- 7 probation, the costs of probation monitoring as well; and
- 8 4. Taking such other and further action as deemed necessary and proper.

9
10 DATED: DEC 17 2021



Reji Varghese
Deputy Director

For: WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

11
12
13
14
15 SF2021401516
16 Larsh.Acc.Final.docx