

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

In the Matter of the Accusation
Against:

Uma Malempati Rao, M.D.

Physician's and Surgeon's
Certificate No. A 78409

Case No.: 800-2019-057609

Respondent.

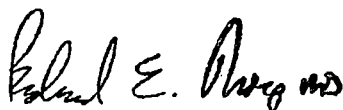
DECISION

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 1, 2023.

IT IS SO ORDERED: November 2, 2023.

MEDICAL BOARD OF CALIFORNIA



Richard E. Thorp, M.D. , Chair
Panel B

1 ROB BONTA
Attorney General of California
2 ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
3 AARON L. LENT
Deputy Attorney General
4 State Bar No. 256857
1300 I Street, Suite 125
5 P.O. Box 944255
Sacramento, CA 94244-2550
6 Telephone: (916) 210-7545
Facsimile: (916) 327-2247
7

8 *Attorneys for Complainant*

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

13 In the Matter of the Accusation Against:

14 **UMA MALEMPATI RAO, M.D.**
15 **1348 W. Herndon Ave., Ste. 101**
Fresno, CA 93711-7181

16 **Physician's and Surgeon's Certificate**
17 **No. A 78409**

18 Respondent.

Case No. 800-2019-057609

OAH No. 2023030187

STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER

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. Reji Varghese (Complainant) is the Executive Director of the Medical Board of
24 California (Board). William Prasifka was the Executive Director of the Board when this action
25 was brought in his official capacity¹ and both are represented in this matter by Rob Bonta,
26 Attorney General of the State of California, by Aaron L. Lent, Deputy Attorney General.

27
28 ¹ William Prasifka resigned as the Executive Director of the Board effective December 30,
2022.

1 2. Respondent Uma Malempati Rao, M.D. (Respondent) is represented in this
2 proceeding by attorney Debra C. Scheufler, Esq., whose address is: 1901 First Avenue, Suite 132
3 San Diego, CA 92101-0308.

4 3. On or about March 20, 2002, the Board issued Physician's and Surgeon's Certificate
5 No. A 78409 to Respondent Uma Malempati Rao, M.D. The Physician's and Surgeon's
6 Certificate was in full force and effect at all times relevant to the charges brought in Accusation
7 No. 800-2019-057609, and will expire on May 31, 2025, unless renewed.

8 **JURISDICTION**

9 4. Accusation No. 800-2019-057609 was filed before the Board, and is currently
10 pending against Respondent. The Accusation and all other statutorily required documents were
11 properly served on Respondent on November 10, 2022. Respondent timely filed her Notice of
12 Defense contesting the Accusation.

13 5. A copy of Accusation No. 800-2019-057609 is attached as Exhibit A and
14 incorporated herein by reference.

15 **ADVISEMENT AND WAIVERS**

16 6. Respondent has carefully read, fully discussed with counsel, and understands the
17 charges and allegations in Accusation No. 800-2019-057609. Respondent has also carefully read,
18 fully discussed with her counsel, and understands the effects of this Stipulated Settlement and
19 Disciplinary Order.

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

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

28 ///

1 CULPABILITY

2 9. Respondent understands and agrees that the charges and allegations in Accusation
3 No. 800-2019-057609, if proven at a hearing, constitute cause for imposing discipline upon her
4 Physician's and Surgeon's Certificate.

5 10. Respondent agrees that, at a hearing, Complainant could establish a *prima facie* case
6 or factual basis for the charges in the Accusation, and that Respondent hereby gives up her right
7 to contest those charges.

8 11. Respondent does not contest that, at an administrative hearing, Complainant could
9 establish a *prima facie* case with respect to the charges and allegations in Accusation No. 800-
10 2019-056375, a true and correct copy of which is attached hereto as Exhibit A, and that she has
11 thereby subjected her Physician's and Surgeon's Certificate, No. A 78409 to disciplinary action.

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

15 CONTINGENCY

16 13. This stipulation shall be subject to approval by the Medical Board of California.
17 Respondent understands and agrees that counsel for Complainant and the staff of the Medical
18 Board of California may communicate directly with the Board regarding this stipulation and
19 settlement, without notice to or participation by Respondent or her counsel. By signing the
20 stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek
21 to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails
22 to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary
23 Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal
24 action between the parties, and the Board shall not be disqualified from further action by having
25 considered this matter.

26 14. Respondent agrees that if she ever petitions for early termination or modification of
27 probation, or if an accusation and/or petition to revoke probation is filed against her before the
28 Board, all of the charges and allegations contained in Accusation No. 800-2019-057609 shall be

1 deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or
2 any other licensing proceeding involving Respondent in the State of California.

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

6 16. The parties agree that copies of this Stipulated Settlement and Disciplinary Order,
7 including copies of the signatures of the parties, may be used in lieu of original documents and
8 signatures and, further, that such copies shall have the same force and effect as originals.

9 17. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to
10 be an integrated writing representing the complete, final, and exclusive embodiment of the
11 agreements of the parties in the above-entitled matter.

12 18. In consideration of the foregoing admissions and stipulations, the parties agree that
13 the Board may, without further notice or opportunity to be heard by the Respondent, issue and
14 enter the following Disciplinary Order:

15 **DISCIPLINARY ORDER**

16 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 78409 issued
17 to Respondent UMA MALEMPATI RAO, M.D. is revoked. However, the revocation is stayed
18 and Respondent is placed on probation for thirty-five (35) months on the following terms and
19 conditions:

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

1 hours of CME of which 40 hours were in satisfaction of this condition.

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

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

16 Respondent shall submit a certification of successful completion to the Board or its
17 designee not later than 15 calendar days after successfully completing the course, or not later than
18 15 calendar days after the effective date of the Decision, whichever is later.

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

28 The Board or its designee shall provide the approved monitor with copies of the Decision(s)

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

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

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

16 The monitor(s) shall submit a quarterly written report to the Board or its designee which
17 includes an evaluation of Respondent's performance, indicating whether Respondent's practices
18 are within the standards of practice of medicine, and whether Respondent is practicing medicine
19 safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure
20 that the monitor submits the quarterly written reports to the Board or its designee within 10
21 calendar days after the end of the preceding quarter.

22 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of
23 such resignation or unavailability, submit to the Board or its designee, for prior approval, the
24 name and qualifications of a replacement monitor who will be assuming that responsibility within
25 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60
26 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a
27 notification from the Board or its designee to cease the practice of medicine within three (3)
28 calendar days after being so notified. Respondent shall cease the practice of medicine until a

1 replacement monitor is approved and assumes monitoring responsibility.

2 In lieu of a monitor, Respondent may participate in a professional enhancement program
3 approved in advance by the Board or its designee that includes, at minimum, quarterly chart
4 review, semi-annual practice assessment, and semi-annual review of professional growth and
5 education. Respondent shall participate in the professional enhancement program at Respondent's
6 expense during the term of probation.

7 4. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the
8 Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the
9 Chief Executive Officer at every hospital where privileges or membership are extended to
10 Respondent, at any other facility where Respondent engages in the practice of medicine,
11 including all physician and locum tenens registries or other similar agencies, and to the Chief
12 Executive Officer at every insurance carrier which extends malpractice insurance coverage to
13 Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15
14 calendar days.

15 This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

16 5. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE
17 NURSES. During probation, Respondent is prohibited from supervising physician assistants and
18 advanced practice nurses.

19 6. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules
20 governing the practice of medicine in California and remain in full compliance with any court
21 ordered criminal probation, payments, and other orders.

22 7. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby
23 ordered to reimburse the Board its costs of investigation and enforcement, including, but not
24 limited to, expert review, amended accusations, legal reviews, investigations, and subpoena
25 enforcement, as applicable, in the amount of \$61,454.10 (sixty-one thousand four hundred fifty-
26 four dollars and ten cents). Costs shall be payable to the Medical Board of California. Failure to
27 pay such costs shall be considered a violation of probation.

28 Payment must be made in full within 30 calendar days of the effective date of the Order, or

1 by a payment plan approved by the Medical Board of California. Any and all requests for a
2 payment plan shall be submitted in writing by respondent to the Board. Failure to comply with
3 the payment plan shall be considered a violation of probation.

4 The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to
5 repay investigation and enforcement costs, including expert review costs.

6 8. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations
7 under penalty of perjury on forms provided by the Board, stating whether there has been
8 compliance with all the conditions of probation.

9 Respondent shall submit quarterly declarations not later than 10 calendar days after the end
10 of the preceding quarter.

11 9. GENERAL PROBATION REQUIREMENTS.

12 Compliance with Probation Unit

13 Respondent shall comply with the Board's probation unit.

14 Address Changes

15 Respondent shall, at all times, keep the Board informed of Respondent's business and
16 residence addresses, email address (if available), and telephone number. Changes of such
17 addresses shall be immediately communicated in writing to the Board or its designee. Under no
18 circumstances shall a post office box serve as an address of record, except as allowed by Business
19 and Professions Code section 2021, subdivision (b).

20 Place of Practice

21 Respondent shall not engage in the practice of medicine in Respondent's or patient's place
22 of residence, unless the patient resides in a skilled nursing facility or other similar licensed
23 facility.

24 License Renewal

25 Respondent shall maintain a current and renewed California physician's and surgeon's
26 license.

27 Travel or Residence Outside California

28 Respondent shall immediately inform the Board or its designee, in writing, of travel to any

1 areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty
2 (30) calendar days.

3 In the event Respondent should leave the State of California to reside or to practice
4 Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of
5 departure and return.

6 10. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be
7 available in person upon request for interviews either at Respondent's place of business or at the
8 probation unit office, with or without prior notice throughout the term of probation.

9 11. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
10 its designee in writing within 15 calendar days of any periods of non-practice lasting more than
11 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
12 defined as any period of time Respondent is not practicing medicine as defined in Business and
13 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct
14 patient care, clinical activity or teaching, or other activity as approved by the Board. If
15 Respondent resides in California and is considered to be in non-practice, Respondent shall
16 comply with all terms and conditions of probation. All time spent in an intensive training
17 program which has been approved by the Board or its designee shall not be considered non-
18 practice and does not relieve Respondent from complying with all the terms and conditions of
19 probation. Practicing medicine in another state of the United States or Federal jurisdiction while
20 on probation with the medical licensing authority of that state or jurisdiction shall not be
21 considered non-practice. A Board-ordered suspension of practice shall not be considered as a
22 period of non-practice.

23 In the event Respondent's period of non-practice while on probation exceeds 18 calendar
24 months, Respondent shall successfully complete the Federation of State Medical Board's Special
25 Purpose Examination, or, at the Board's discretion, a clinical competence assessment program
26 that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model
27 Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

28 Respondent's period of non-practice while on probation shall not exceed two (2) years.

1 Periods of non-practice will not apply to the reduction of the probationary term.

2 Periods of non-practice for a Respondent residing outside of California will relieve
3 Respondent of the responsibility to comply with the probationary terms and conditions with the
4 exception of this condition and the following terms and conditions of probation: Obey All Laws;
5 General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or
6 Controlled Substances; and Biological Fluid Testing..

7 12. COMPLETION OF PROBATION. Respondent shall comply with all financial
8 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the
9 completion of probation. This term does not include cost recovery, which is due within 30
10 calendar days of the effective date of the Order, or by a payment plan approved by the Medical
11 Board and timely satisfied. Upon successful completion of probation, Respondent's certificate
12 shall be fully restored.

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

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

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

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

7 16. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for
8 a new license or certification, or petition for reinstatement of a license, by any other health care
9 licensing action agency in the State of California, all of the charges and allegations contained in
10 Accusation No. 800-2019-057609 shall be deemed to be true, correct, and admitted by
11 Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or
12 restrict license.

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1 ACCEPTANCE

2 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
3 discussed it with my attorney, Debra C. Scheufler, Esq.. I understand the stipulation and the
4 effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated
5 Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be
6 bound by the Decision and Order of the Medical Board of California.

7
8 DATED: 8/2/23 Uma Malempati Rao MD
9 UMA MALEMPATI RAO, M.D.
10 *Respondent*

11 I have read and fully discussed with Respondent Uma Malempati Rao, M.D. the terms and
12 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.
13 I approve its form and content.

14 DATED: 8/2/2023 Debra C. Scheufler, Esq.
15 *Attorney for Respondent*

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: 8/4/2023

20 Respectfully submitted,

21 ROB BONTA
22 Attorney General of California
23 ALEXANDRA M. ALVAREZ
24 Supervising Deputy Attorney General

25 Aaron L. Lent
26 AARON L. LENT
27 Deputy Attorney General
28 *Attorneys for Complainant*

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1 ROB BONTA
Attorney General of California
2 STEVE DIEHL
Supervising Deputy Attorney General
3 AARON L. LENT
Deputy Attorney General
4 State Bar No. 256857
1300 I Street, Suite 125
5 P.O. Box 944255
Sacramento, CA 94244-2550
6 Telephone: (916) 210-7545
Facsimile: (916) 327-2247
7

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10 **BEFORE THE**
11 **MEDICAL BOARD OF CALIFORNIA**
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13 In the Matter of the Accusation Against:

Case No. 800-2019-057609

14 **Uma Malempati Rao, M.D.**
1348 W. Herndon Ave., Ste. 101
15 Fresno, CA 93711-7181

A C C U S A T I O N

16 **Physician's and Surgeon's Certificate**
17 **No. A 78409,**

18 Respondent.

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 or about March 20, 2002, the Medical Board issued Physician's and Surgeon's
25 Certificate No. A 78409 to Uma Malempati Rao, M.D. (Respondent). The Physician's and
26 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
27 herein and will expire on May 31, 2023, unless renewed.

28 ///

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 (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

STATUTORY PROVISIONS

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 that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

(g) The 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.

1 6. Unprofessional conduct under Section 2234 of the Code is conduct which breaches
2 the rules or ethical code of the medical profession, or conduct which is unbecoming to a member
3 in good standing of the medical profession, which demonstrates an unfitness to practice medicine.
4 (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

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

8 8. Section 3502 of the Code states, in pertinent part:

9 (a) Notwithstanding any other law, a physician assistant may perform those medical
10 services as set forth by the regulations adopted under this chapter when the services are
11 rendered under the supervision of a licensed physician and surgeon who is not subject to a
12 disciplinary condition imposed by the Medical Board of California prohibiting that
13 supervision or prohibiting the employment of a physician assistant. The medical record,
14 for each episode of care for a patient, shall identify the physician and surgeon who is
15 responsible for the supervision of the physician assistant.

16 (b)(1) Notwithstanding any other law, a physician assistant performing medical
17 services under the supervision of a physician and surgeon may assist a doctor of podiatric
18 medicine who is a partner, shareholder, or employee in the same medical group as the
19 supervising physician and surgeon. A physician assistant who assists a doctor of podiatric
20 medicine pursuant to this subdivision shall do so only according to patient-specific orders
21 from the supervising physician and surgeon.

22 (2) The supervising physician and surgeon shall be physically available to the
23 physician assistant for consultation when that assistance is rendered. A physician assistant
24 assisting a doctor of podiatric medicine shall be limited to performing those duties included
25 within the scope of practice of a doctor of podiatric medicine.

26 (c)(1) A physician assistant and his or her supervising physician and surgeon shall
27 establish written guidelines for the adequate supervision of the physician assistant. This
28 requirement may be satisfied by the supervising physician and surgeon adopting protocols
for some or all of the tasks performed by the physician assistant. The protocols adopted
pursuant to this subdivision shall comply with the following requirements:

(A) A protocol governing diagnosis and management shall, at a minimum, include
the presence or absence of symptoms, signs, and other data necessary to establish a
diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to
the patient, and education to be provided to the patient.

(B) A protocol governing procedures shall set forth the information to be provided to
the patient, the nature of the consent to be obtained from the patient, the preparation and
technique of the procedure, and the followup care.

1 (C) Protocols shall be developed by the supervising physician and surgeon or
2 adopted from, or referenced to, texts or other sources.

3 (D) Protocols shall be signed and dated by the supervising physician and surgeon and
4 the physician assistant.

5 (2)(A) The supervising physician and surgeon shall use one or more of the following
6 mechanisms to ensure adequate supervision of the physician assistant functioning under the
7 protocols:

8 (i) The supervising physician and surgeon shall review, countersign, and date a
9 sample consisting of, at a minimum, 5 percent of the medical records of patients treated by
10 the physician assistant functioning under the protocols within 30 days of the date of
11 treatment by the physician assistant.

12 (ii) The supervising physician and surgeon and physician assistant shall conduct a
13 medical records review meeting at least once a month during at least 10 months of the year.
14 During any month in which a medical records review meeting occurs, the supervising
15 physician and surgeon and physician assistant shall review an aggregate of at least 10
16 medical records of patients treated by the physician assistant functioning under protocols.
17 Documentation of medical records reviewed during the month shall be jointly signed and
18 dated by the supervising physician and surgeon and the physician assistant.

19 (iii) The supervising physician and surgeon shall review a sample of at least 10
20 medical records per month, at least 10 months during the year, using a combination of the
21 countersignature mechanism described in clause (i) and the medical records review meeting
22 mechanism described in clause (ii). During each month for which a sample is reviewed, at
23 least one of the medical records in the sample shall be reviewed using the mechanism
24 described in clause (i) and at least one of the medical records in the sample shall be
25 reviewed using the mechanism described in clause (ii).

26 (B) In complying with subparagraph (A), the supervising physician and surgeon shall
27 select for review those cases that by diagnosis, problem, treatment, or procedure represent,
28 in his or her judgment, the most significant risk to the patient.

(3) Notwithstanding any other law, the Medical Board of California or the board may
establish other alternative mechanisms for the adequate supervision of the physician
assistant.

(d) No medical services may be performed under this chapter in any of the following
areas:

(1) The determination of the refractive states of the human eye, or the fitting or
adaptation of lenses or frames for the aid thereof.

(2) The prescribing or directing the use of, or using, any optical device in connection
with ocular exercises, visual training, or orthoptics.

(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses
to, the human eye.

(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as
defined in Chapter 4 (commencing with Section 1600).

1 (e) This section shall not be construed in a manner that shall preclude the
2 performance of routine visual screening as defined in Section 3501.

3 (f) Compliance by a physician assistant and supervising physician and surgeon with
4 this section shall be deemed compliance with Section 1399.546 of Title 16 of the California
5 Code of Regulations.

6 9. Section 3502.1 of the Code states, in pertinent part:

7 (a) In addition to the services authorized in the regulations adopted by the Medical
8 Board of California, and except as prohibited by Section 3502, while under the supervision
9 of a licensed physician and surgeon or physicians and surgeons authorized by law to
10 supervise a physician assistant, a physician assistant may administer or provide medication
11 to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order
12 to a person who may lawfully furnish the medication or medical device pursuant to
13 subdivisions (c) and (d).

14 (1) A supervising physician and surgeon who delegates authority to issue a drug
15 order to a physician assistant may limit this authority by specifying the manner in which the
16 physician assistant may issue delegated prescriptions.

17 (2) Each supervising physician and surgeon who delegates the authority to issue a
18 drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice
19 specific, formulary and protocols that specify all criteria for the use of a particular drug or
20 device, and any contraindications for the selection. Protocols for Schedule II controlled
21 substances shall address the diagnosis of illness, injury, or condition for which the Schedule
22 II controlled substance is being administered, provided, or issued. The drugs listed in the
23 protocols shall constitute the formulary and shall include only drugs that are appropriate for
24 use in the type of practice engaged in by the supervising physician and surgeon. When
25 issuing a drug order, the physician assistant is acting on behalf of and as an agent for a
26 supervising physician and surgeon.

27 (b) "Drug order," for purposes of this section, means an order for medication that is
28 dispensed to or for a patient, issued and signed by a physician assistant acting as an
individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of
Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued
pursuant to this section shall be treated in the same manner as a prescription or order of the
supervising physician, (2) all references to "prescription" in this code and the Health and
Safety Code shall include drug orders issued by physician assistants pursuant to authority
granted by their supervising physicians and surgeons, and (3) the signature of a physician
assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of
this code and the Health and Safety Code.

(c) A drug order for any patient cared for by the physician assistant that is issued by
the physician assistant shall either be based on the protocols described in subdivision (a) or
shall be approved by the supervising physician and surgeon before it is filled or carried out.

(1) A physician assistant shall not administer or provide a drug or issue a drug order
for a drug other than for a drug listed in the formulary without advance approval from a
supervising physician and surgeon for the particular patient. At the direction and under the
supervision of a physician and surgeon, a physician assistant may hand to a patient of the

1 supervising physician and surgeon a properly labeled prescription drug prepackaged by a
2 physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

3 (2) A physician assistant shall not administer, provide, or issue a drug order to a
4 patient for Schedule II through Schedule V controlled substances without advance approval
5 by a supervising physician and surgeon for that particular patient unless the physician
6 assistant has completed an education course that covers controlled substances and that
7 meets standards, including pharmacological content, approved by the board. The
8 education course shall be provided either by an accredited continuing education provider or
9 by an approved physician assistant training program. If the physician assistant will
10 administer, provide, or issue a drug order for Schedule II controlled substances, the course
11 shall contain a minimum of three hours exclusively on Schedule II controlled substances.
12 Completion of the requirements set forth in this paragraph shall be verified and documented
13 in the manner established by the board prior to the physician assistant's use of a registration
14 number issued by the United States Drug Enforcement Administration to the physician
15 assistant to administer, provide, or issue a drug order to a patient for a controlled substance
16 without advance approval by a supervising physician and surgeon for that particular patient.

17 (3) Any drug order issued by a physician assistant shall be subject to a reasonable
18 quantitative limitation consistent with customary medical practice in the supervising
19 physician and surgeon's practice.

20 (d) A written drug order issued pursuant to subdivision (a), except a written drug
21 order in a patient's medical record in a health facility or medical practice, shall contain the
22 printed name, address, and telephone number of the supervising physician and surgeon, the
23 printed or stamped name and license number of the physician assistant, and the signature of
24 the physician assistant. Further, a written drug order for a controlled substance, except a
25 written drug order in a patient's medical record in a health facility or a medical practice,
26 shall include the federal controlled substances registration number of the physician assistant
27 and shall otherwise comply with Section 11162.1 of the Health and Safety Code. Except
28 as otherwise required for written drug orders for controlled substances under Section
11162.1 of the Health and Safety Code, the requirements of this subdivision may be met
through stamping or otherwise imprinting on the supervising physician and surgeon's
prescription blank to show the name, license number, and if applicable, the federal
controlled substances registration number of the physician assistant, and shall be signed by
the physician assistant. When using a drug order, the physician assistant is acting on
behalf of and as the agent of a supervising physician and surgeon.

(e) The supervising physician and surgeon shall use either of the following
mechanisms to ensure adequate supervision of the administration, provision, or issuance by
a physician assistant of a drug order to a patient for Schedule II controlled substances:

(1) The medical record of any patient cared for by a physician assistant for whom the
physician assistant's Schedule II drug order has been issued or carried out shall be
reviewed, countersigned, and dated by a supervising physician and surgeon within seven
days.

(2) If the physician assistant has documentation evidencing the successful
completion of an education course that covers controlled substances, and that controlled
substance education course (A) meets the standards, including pharmacological content,
established in Sections 1399.610 and 1399.612 of Title 16 of the California Code of

1 Regulations , and (B) is provided either by an accredited continuing education provider or
2 by an approved physician assistant training program, the supervising physician and surgeon
3 shall review, countersign, and date, within seven days, a sample consisting of the medical
4 records of at least 20 percent of the patients cared for by the physician assistant for whom
5 the physician assistant's Schedule II drug order has been issued or carried out. Completion
6 of the requirements set forth in this paragraph shall be verified and documented in the
7 manner established in Section 1399.612 of Title 16 of the California Code of Regulations.
8 Physician assistants who have a certificate of completion of the course described in
9 paragraph (2) of subdivision (c) shall be deemed to have met the education course
10 requirement of this subdivision.

11 (f) All physician assistants who are authorized by their supervising physicians to
12 issue drug orders for controlled substances shall register with the United States Drug
13 Enforcement Administration (DEA).

14 (g) The board shall consult with the Medical Board of California and report during
15 its sunset review required by Article 7.5 (commencing with Section 9147.7) of Chapter 1.5
16 of Part 1 of Division 2 of Title 2 of the Government Code the impacts of exempting
17 Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon
18 to review and countersign the affected medical record of a patient.

19 10. Section 3527 of the Code states, in pertinent part:

20 ...

21 (c) The Medical Board of California may order the denial of an application for, or the
22 issuance subject to terms and conditions of, or the suspension or revocation of, or the
23 imposition of probationary conditions upon, an approval to supervise a physician assistant,
24 after a hearing as required in Section 3528, for unprofessional conduct, which includes, but
25 is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a
26 violation of the regulations adopted by the board or the Medical Board of California.

27 ...

28 REGULATORY PROVISIONS

11. California Code of Regulations, title 16, section 1399.541, states, in pertinent part:

Because physician assistant practice is directed by a supervising physician, and a
physician assistant acts as an agent for that physician, the orders given and tasks performed
by a physician assistant shall be considered the same as if they had been given and
performed by the supervising physician...

...

12. California Code of Regulations, title 16, section 1399.545, states:

(a) A supervising physician shall be available in person or by electronic
communication at all times when the physician assistant is caring for patients.

(b) A supervising physician shall delegate to a physician assistant only those

1 tasks and procedures consistent with the supervising physician's specialty or usual
2 and customary practice and with the patient's health and condition.

3 (c) A supervising physician shall observe or review evidence of the physician
4 assistant's performance of all tasks and procedures to be delegated to the physician
5 assistant until assured of competency.

6 (d) The physician assistant and the supervising physician shall establish in
7 writing transport and back-up procedures for the immediate care of patients who are
8 in need of emergency care beyond the physician assistant's scope of practice for such
9 times when a supervising physician is not on the premises.

10 (e) A physician assistant and his or her supervising physician shall establish in
11 writing guidelines for the adequate supervision of the physician assistant which shall
12 include one or more of the following mechanisms:

13 (1) Examination of the patient by a supervising physician the same day as care
14 is given by the physician assistant;

15 (2) Countersignature and dating of all medical records written by the physician
16 assistant within thirty (30) days that the care was given by the physician assistant;

17 (3) The supervising physician may adopt protocols to govern the performance
18 of a physician assistant for some or all tasks. The minimum content for a protocol
19 governing diagnosis and management as referred to in this section shall include the
20 presence or absence of symptoms, signs, and other data necessary to establish a
21 diagnosis or assessment, any appropriate tests or studies to order, drugs to
22 recommend to the patient, and education to be given the patient. For protocols
23 governing procedures, the protocol shall state the information to be given the patient,
24 the nature of the consent to be obtained from the patient, the preparation and
25 technique of the procedure, and the follow-up care. Protocols shall be developed by
26 the physician, adopted from, or referenced to, texts or other sources. Protocols shall
27 be signed and dated by the supervising physician and the physician assistant. The
28 supervising physician shall review, countersign, and date a minimum of 5% sample of
medical records of patients treated by the physician assistant functioning under these
protocols within thirty (30) days. The physician shall select for review those cases
which by diagnosis, problem, treatment or procedure represent, in his or her
judgment, the most significant risk to the patient;

(4) Other mechanisms approved in advance by the board.

(f) The supervising physician has continuing responsibility to follow the
progress of the patient and to make sure that the physician assistant does not function
autonomously. The supervising physician shall be responsible for all medical
services provided by a physician assistant under his or her supervision.

COST RECOVERY

13. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
administrative law judge to direct a licensee found to have committed a violation or violations of
the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
enforcement of the case, with failure of the licensee to comply subjecting the license to not being

1 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be
2 included in a stipulated settlement.

3 **FACTUAL ALLEGATIONS**

4 14. Respondent is a licensed physician and surgeon, board certified in internal medicine,
5 who at all times relevant to the allegations worked at EuroPhoria Medical Spa (EuroPhoria)
6 within Kern County, California. Respondent began working at EuroPhoria on the weekends in
7 late 2018 until August 1, 2019, when Respondent became the sole owner and medical director of
8 EuroPhoria.

9 15. During Respondent's investigative interview, Respondent stated that she reviews all
10 patient charts at EuroPhoria. Respondent also stated that she is only physically present at
11 EuroPhoria for approximately one weekend or three days each month. Respondent further stated
12 that she supervises two physician assistants employed at EuroPhoria who conduct the good faith
13 examinations (GFE), are located off-site, and are never physically present at EuroPhoria.

14 16. On or about July 14, 2021, authorities executed a Kern County Superior Court search
15 warrant of EuroPhoria, its warehouse, as well as the Respondent and other EuroPhoria staff and
16 personnel. Patients who were present at EuroPhoria at the time the warrant was executed signed
17 authorizations of release of their records and their EuroPhoria medical records were obtained with
18 a declaration of certified records from the EuroPhoria assistant manager. Photographs and video
19 imaging, accompanied with audio recordings were also obtained the same day by an undercover
20 agent at EuroPhoria posing as a patient.

21 **Patient 1¹**

22 17. Patient 1, a 34-year-old female patient, received cosmetic treatments at EuroPhoria
23 beginning in early 2021 consisting of Xeomin² injections. /

24 ///

25 ///

26 ¹ To protect the privacy of the patients and witnesses involved, the patients and witnesses
27 names were not included in this pleading. Respondent is aware of the identity of each patient and
witness. All patients and witnesses will be fully identified in discovery.

28 ² Xeomin (incobotulinumtoxinA) is Botulinum Toxin Type A, otherwise known as Botox,
that blocks nerve activity in the muscles, causing a temporary reduction in muscle activity.

1 18. According to Patient 1's medical records, Patient 1 scheduled cosmetic wrinkle
2 relaxer appointments at EuroPhoria on or about February 17, 2021, June 22, 2021, and July 14,
3 2021.

4 19. On or about February 17, 2021, Patient 1 signed a document titled "Botulinum A
5 Toxin Informed Consent." The document was not co-signed by Respondent or any representative
6 of EuroPhoria, nor were Respondent or EuroPhoria mentioned in the document. There was no
7 indication in the medical record that it was reviewed with Patient 1 to determine Patient 1's
8 competency, verification that she was adequately informed, and not coerced. No other informed
9 consent document appeared in Patient 1's EuroPhoria medical records.

10 20. On or about February 17, 2021, Patient 1 filled out and signed a two-page EuroPhoria
11 form document titled "Client Information & Medical History" as well as a questionnaire. Neither
12 document was co-signed by Respondent or any representative of EuroPhoria, nor was there any
13 indication in the medical record that they were reviewed with Patient 1. The sections of the
14 document for the physical exam and cosmetic evaluation were blank. Neither the basis of Patient
15 1's office visit nor Patient 1's chief complaint were documented in Patient 1's medical records.

16 21. According to Patient 1's medical records, on or about February 17, 2021, a single-
17 page largely yes/no form document titled "Good Faith Exam" (GFE) was filled out and signed
18 with an illegible signature and no printed name of the medical provider. The GFE document
19 classified Patient 1's Fitzpatrick skin³ as III, stated that the "risks, alternatives, and benefits were
20 explained to the patient in detail...all questions were answered and patient wishes to proceed with
21 the treatment as outline above, per protocol...the patient is cleared for all the treatments marked
22 below," and "cleared" Patient 1 for twenty-seven (27) cosmetic procedures. The document
23 contained a small yes/no physical examination component which only determined whether there
24 were signs of facial weakness or eyelid and eyebrow symmetry, asymmetry, facial scars,
25 melisma, blemishes, or lesions. No specific evaluation, assessment or treatment plan of Patient 1
26 was documented as to any of the 27 cosmetic procedures. The GFE was not counter-signed by

27 ³ Fitzpatrick skin types, or phototypes refer to a skin tone scale developed to classify skin
28 coloring and response to ultraviolet radiation to help determine a patient's risk of burning or
tanning when exposed to ultraviolet light.

1 Respondent and there was no documented indication in the medical record that it was reviewed
2 by Respondent.

3 22. On or about June 22, 2021, Patient 1 filled out and signed a two-page EuroPhoria
4 form document titled "Client Information & Medical History." The document was not co-signed
5 by Respondent or any representative of EuroPhoria, nor was there any indication in the medical
6 record that it was reviewed with Patient 1. The sections of the document for the physical exam
7 and cosmetic evaluation were blank and crossed out. No other medical history or prior treatments
8 were documented in Patient 1's medical records other than the same document Patient 1 filled out
9 on February 17, 2021. Neither the basis of Patient 1's office visit nor Patient 1's chief complaint
10 were articulated or stated in Patient 1's medical records.

11 23. According to Patient 1's medical records, on or about June 22, 2021, a single-page
12 largely yes/no form document titled "Good Faith Exam" was filled out and signed with an
13 illegible signature and no printed name of the medical provider. The GFE document classified the
14 patient's Fitzpatrick skin as IV, stated that the "risks, alternatives, and benefits were explained to
15 the patient in detail...all questions were answered and patient wishes to proceed with the
16 treatment as outline above, per protocol...the patient is cleared for all the treatments marked
17 below," and "cleared" Patient 1 for only ten (10) cosmetic procedures. The document contained a
18 small yes/no physical examination component which only determined whether there were signs of
19 facial weakness or eyelid and eyebrow symmetry, asymmetry, facial scars, melisma, blemishes,
20 or lesions. Other than the Fitzpatrick skin and the number of cleared cosmetic procedures, no
21 other information changed from Patient 1's previous February 17, 2021 GFE. No specific
22 evaluation, assessment, or treatment plan of Patient 1 was documented as to any of the 10
23 cosmetic procedures.

24 24. Patient 1's EuroPhoria medical records contain only three sets of photographs of
25 Patient 1 dated February 17, 2021, June 22, 2021, and August 31, 2021. Each set of photographs
26 depict Patient 1 with marked dots on her face and consisted of either two or five photographs for
27 each date. No additional identifying information was provided with the photographs other than
28 the typed dated and Patient 1's name at the top of each page. There was no indication documented

1 in Patient 1's EuroPhoria medical records as to who placed the marked dots on her face or who
2 took the photographs on any given date.

3 25. Patient 1's EuroPhoria medical records contain one page of text/chat dialogue
4 screenshots that indicate Patient 1 underwent Xeomin treatments on February 17, 2021, June 22,
5 2021, August 31, 2021, and January 24, 2022. Patient 1's name, date of birth, medical record
6 number, or any other identifiers were not documented in any of the individual text/chat dialogue
7 screenshots. The typed name of a EuroPhoria's registered nurse or nurse practitioner appeared
8 under each date within each screenshot without identifying what function they performed as to
9 each treatment procedure. While each screenshot stated "Xeomin" with a series of stated facial
10 locations and corresponding numerical values next to them, the exact botulinum toxin was not
11 identified, nor was the lot number, expiration date, or units of measurement used. Each screenshot
12 concluded in the same manner by stating that "post care instructions given," but does not state
13 what the instructions were, to whom they were given, and no additional information was
14 documented in the screenshot. None of these screenshots indicate that Respondent was consulted,
15 reviewed and/or administered any of the treatments to Patient 1. No specific evaluation,
16 assessment or treatment plan of Patient 1 was documented in the medical record.

17 **Patient 2**

18 26. Patient 2, a 52-year-old female patient, received cosmetic treatments at EuroPhoria
19 beginning in mid-2019 consisting of Xeomin injections, vitamin infusion intravenous (IV)
20 therapy, Phentermine,⁴ "Vanquish" treatments,⁵ and "Lipo-B" injections.⁶

21 27. On or about November 12, 2019 and August 5, 2021, Patient 2 signed documents
22 titled "IV Nutrition Therapy/Medical Weight Loss Injections Informed Consent." The documents
23 were signed with illegible witness signatures and no printed name of a medical provider. Neither
24

25 ⁴ Phentermine is a stimulant derived from amphetamine used to suppress appetite and treat
26 obesity. It is a Schedule IV controlled substance pursuant to Code of Federal Regulations title 21
27 section 1308.14(c), and pursuant to Health and Safety Code section 11057(d), and a dangerous
28 drug pursuant to Business and Professions Code section 4022.

⁵ Vanquish treatment is a body contouring procedure utilizing radiofrequency energy
against the body of a patient.

⁶ Lipotropic injections contain a variety of vitamins, nutrients, and amino acids that are
injected into any part of the body that has subcutaneous fatty tissue.

1 Respondent nor EuroPhoria were mentioned in the body of the documents. There was no
2 indication in Patient 2's medical record that they were reviewed with Patient 2 to determine
3 Patient 2's competency, verification that she was adequately informed, and not coerced.

4 28. On or about April 10, 2021, Patient 2 signed a document titled "Vanquish Treatment
5 Consent." The document was blank in three paragraphs that required Patient 2's initials, which
6 explained: (1) that EuroPhoria staff explained the nature of Patient 2's condition, the procedure,
7 its alternatives, and benefits; (2) that the patient confirms not having a pacemaker, internal
8 defibrillator, or other metal implants; and (3) that the patient understands the risks of the
9 procedure. The document was not co-signed by Respondent or any representative of EuroPhoria,
10 and there was no indication in the document or Patient 2's medical record that it was reviewed
11 with Patient 2 to determine Patient 2's competency, verification that she was adequately
12 informed, and not coerced.

13 29. According to Patient 2's medical record, on or about September 12, 2019, October 1,
14 2020, March 10, 2021, and April 27, 2022, a single-page largely yes/no form document titled
15 "Good Faith Exam" was filled out. No other medical examination, patient medical history,
16 physical examination, treatment or assessment plans were documented in Patient 2's medical
17 record. None of the GFEs were counter-signed by Respondent, and there was no documented
18 indication within the medical record that they were reviewed by Respondent.

19 a. The October 2020 GFE was signed with an illegible signature and no printed name of
20 the medical provider.

21 b. Each GFE has a "Patient History" section that consisted of ten (10) check-mark boxes
22 next to ten medical conditions. The September 2019 GFE "Patient History" section had all
23 ten boxes checked with the word "no" next to them with an additional notation regarding
24 breast implants. The October 2020 and March 2021 GFE's also had all ten boxes checked
25 with the word "no" next to them, but without any notation regarding breast implants. The
26 April 2022 GFE only had two boxes checked with the word "no" next to them with the
27 other eight boxes blank and no notation regarding breast implants.

28 ///

1 c. Each GFE had a "Medication" section that also provided a space for allergies. Only
2 the September 2019 GFE indicated Patient 2 had a bee allergy and no sensitivity to nitrous
3 oxide.

4 d. Each GFE had a "Physical Exam" section that consisted of two to three yes/no
5 questions, a space for notes regarding asymmetries, and a space to list facial scars, melisma,
6 blemishes, and lesions. Only the October 2020 and March 2021 GFE's documented Patient
7 2's blood pressure, heart rate, and weight. Only the September 2019 and April 2022 GFE's
8 documented no presence of metal implants in the patient, but only the September 2019 GFE
9 documented the presence of breast implants. Only the April 2022 documented the presence
10 of moles on Patient 2 but did not elaborate as to their number, locations, size, color, etc.
11 Only the March 2021 GFE documented the patient experiencing a secondary effect of
12 Phentermine but no additional information was documented such as the extent of the effect
13 on Patient 2.

14 e. Each GFE had a "Cosmetic Evaluation" section that consisted of ten yes/no check-
15 marked boxes. Only the October 2020 GFE had no boxes that were checked.

16 f. Each GFE had a section at the bottom of the single-page document listing
17 approximately thirty (30) cosmetic treatments and procedures with check-mark boxes next
18 to each one that indicate approval or "clearance" for the patient to receive or not the
19 treatment or procedure. The September 2019 GFE indicated Patient 2 was "cleared" to
20 receive half of the procedures. The October 2020 GFE only had the Phentermine treatment
21 checked. The March 2021 GFE indicated Patient 2 was "cleared" to receive eighteen of the
22 procedures. The April 2022 GFE indicated Patient 2 was "cleared" to receive almost all of
23 the procedures and treatments listed. No further evaluation, assessment or treatment plan of
24 Patient 2 was documented as to any of the cosmetic procedures and treatments listed on the
25 GFEs.

26 30. Patient 2's EuroPhoria medical records contained nine sets of photographs of Patient
27 2 dated September 12, 2019, January 25, 2020, July 15, 2020, December 9, 2020, May 1, 2021,
28 August 5, 2021, November 3, 2021, February 1, 2022, and April 27, 2022. Each set of

1 photographs depicted Patient 2 with marked dots on her face, except for May 1, 2021 which
2 depicts Patient 2's upper torso. No additional identifying information is provided with the
3 photographs other than the typed date and Patient 2's name at the top of each page. Some of the
4 photographs contained the name of a EuroPhoria registered nurse at the top of the page that the
5 photographs appear on; however, there was no indication documented in Patient 2's EuroPhoria
6 medical records as to who placed the marked dots on her face or who took the photographs on
7 any given date.

8 31. Patient 2's EuroPhoria medical records contained seven pages of text/chat dialogue
9 screenshots that indicated Patient 2 underwent approximately twenty-one (21) cosmetic
10 treatments and procedures at EuroPhoria from September 2019 through April 2022. Patient 2's
11 name, date of birth, medical record number, or any other identifiers were not documented in any
12 of the individual text/chat dialogue screenshots. The typed name of a EuroPhoria registered nurse
13 or nurse practitioner appeared under each date within each screenshot without identifying what
14 function they performed as to each treatment procedure. None of these screenshots indicated that
15 Respondent was consulted, reviewed and/or administered any of the individual treatments or
16 procedures Patient 2 received. No specific evaluation, assessment or treatment plan of Patient 2
17 was documented in any of the screenshots. According to these seven pages of text/chat dialogue
18 screenshots, Patient 2 underwent the following cosmetic treatments and procedures on the dates
19 indicated at EuroPhoria:

20 a. Xeomin injections – April 27, 2022, February 1, 2022, December 21, 2021,
21 November 3, 2021, and September 22, 2021. While each screenshot stated "Xeomin" with a
22 series of stated facial locations and corresponding numerical values next to them, the exact
23 botulinum toxin was not identified, nor was the lot number, expiration date, or units of
24 measurement used. Each screenshot concluded in the same manner by stating that "post
25 care instructions given" but does not state what the instructions were, to whom they were
26 given, and no additional information was documented in the screenshot.

27 b. "Lipo-B" injections – November 3, 2021, September 22, 2021, September 15, 2021,
28 September 8, 2021, and August 5, 2021. None of the screenshots stated the composition of

1 vitamins, nutrients, or amino acids that were injected into Patient 2 on each date. Each
2 screenshot concluded in the same manner by stating that “after care instructions given” but
3 does not state what the instructions were, to whom they were given, and no additional
4 information was documented in the screenshot.

5 c. Botox injections – August 5, 2021, December 9, 2020, January 25, 2020, and
6 September 12, 2019. While each screenshot stated “Botox” with a series of stated facial
7 locations and corresponding numerical values next to them, the exact botulinum toxin was
8 not identified, nor was the lot number, expiration date, or units of measurement used. Each
9 screenshot concluded in the same manner by stating that “post care instructions given” but
10 does not state what the instructions were, to whom they were given, and no additional
11 information was documented in the screenshot.

12 d. Phentermine – June 12, 2021, April 10, 2021, March 10, 2021, October 24, 2020,
13 October 1, 2020, and November 24, 2019.

14 e. “Vanquish” treatments – May 11, 2021, twice on May 1, 2021, twice on April 24,
15 2021, and April 10, 2021.

16 f. IV therapy – December 14, 2019.

17 32. Patient 2’s EuroPhoria medical records contained a single typed page stating, “I, Dr.
18 Rao, Have reviewed this medical chart.” Patient 2’s name is typed underneath the statement with
19 a date of November 29, 2019 and the page is signed by the Respondent. There are no further
20 explanations or descriptions of what portion of Patient 2’s charts and/or medical records were
21 reviewed and assessed, what the review encompassed, or whether Respondent approved any
22 specific procedures or treatments given to Patient 2 or had any other comments. There are no
23 other indications that Respondent reviewed Patient 2’s medical record on any other date.

24 **Patient 3**

25 33. Patient 3, a 37-year-old female patient, went to EuroPhoria on July 14, 2021.

26 34. On or about July 14, 2021, Patient 3 signed a document titled “Botulinum A Toxin
27 Informed Consent.” The document was not co-signed by Respondent or any representative of
28 EuroPhoria, nor were Respondent or EuroPhoria mentioned in the document. There was no

1 indication in the document that it was reviewed with Patient 3 to determine Patient 3's
2 competency, verification that she was adequately informed, and not coerced. No other informed
3 consent document appeared in Patient 3's EuroPhoria medical record.

4 35. On or about July 14, 2021, Patient 3 filled out and signed a two-page EuroPhoria
5 form document titled "Client Information & Medical History" as well as a questionnaire. Neither
6 document was co-signed by Respondent or any representative of EuroPhoria, nor was there any
7 indication in the medical record that they were reviewed with Patient 3. The sections of the
8 document for the physical exam and cosmetic evaluation were blank. Neither the basis of Patient
9 3's office visit nor Patient 3's chief complaint were articulated or stated in the medical record.

10 36. According to Patient 3's medical record, on or about July 14, 2021, a single-page
11 largely yes/no form document titled "Good Faith Exam" (GFE) was filled out and signed with an
12 illegible signature and no printed name of the medical provider. The bottom of the document
13 contained a stamp with the identifying information of a EuroPhoria physician assistant. No other
14 medical examination, patient medical history, physical examination, treatment or assessment
15 plans were documented in Patient 3's medical record. The GFE was not counter-signed by the
16 Respondent and there was no documented indication within the medical record that it was
17 reviewed by Respondent. The "Patient History" section of the GFE consists of eight (8) check-
18 mark boxes next to eight medical conditions, of which all eight boxes were checked with the
19 word "no" next to them. The GFE had a "Physical Exam" section that consisted of two yes/no
20 questions, a space for notes regarding asymmetries, and a space to list facial scars, melisma,
21 blemishes, and lesions. The spaces on the GFE denoting Patient 3's weight, height, blood
22 pressure, and heart rate were blank. The "Cosmetic Evaluation" section of the GFE consisted of
23 ten check-mark boxes, of which only four boxes were checked. At the bottom of the single-page
24 GFE was a listing of approximately thirty (30) cosmetic treatments and procedures with check-
25 mark boxes next to each one that indicate approval or "clearance" for the patient to receive or not
26 the treatment or procedure, of which Patient 3 was "cleared" to receive over half of the
27 procedures. No specific evaluation, assessment, or treatment plan of Patient 3 was documented as
28 each of the approved cosmetic procedures.

1 37. Patient 3's EuroPhoria medical records contained only one set of photographs of
2 Patient 3 dated July 14, 2021. The set of photographs depicts Patient 3 with marked dots on her
3 face and consisted of four photographs. No additional identifying information was provided with
4 the photographs other than the typed date and Patient 3's name at the top of the page. There was
5 no indication documented in Patient 3's EuroPhoria medical records as to who placed the marked
6 dots on her face or who took the photographs.

7 38. Patient 3's EuroPhoria medical records contained a single typed page stating, "Patient
8 did not receive medical treatment. Raid occurred before treatment began. Did not receive any
9 medical treatment before or after raid occurred." Patient 3's name was typed above the statement.
10 The page was not dated or signed. No other information was contained in the page.

11 **Patient 4**

12 39. Patient 4, an adult female patient, received cosmetic treatments at EuroPhoria
13 beginning in February 2021 through November 2021 consisting of Xeomin injections.

14 40. On or about February 18, 2021, Patient 4 signed a document titled "Botulinum A
15 Toxin Informed Consent." The document was not co-signed by Respondent or any representative
16 of EuroPhoria, nor were Respondent or EuroPhoria mentioned in the document. There was no
17 indication in the medical record that it was reviewed with Patient 4 to determine Patient 4's
18 competency, verification that she was adequately informed, and not coerced. No other informed
19 consent document appeared in Patient 4's EuroPhoria medical record.

20 41. On or about February 18, 2021, Patient 4 filled out and signed a two-page EuroPhoria
21 form document titled "Client Information & Medical History." The document was not co-signed
22 by Respondent or any representative of EuroPhoria, nor was there any indication in the document
23 that it was reviewed with Patient 4. The sections of the document for the physical exam and
24 cosmetic evaluation were blank. Neither the basis of Patient 4's office visit nor the patient's chief
25 complaint were articulated or stated in the medical record.

26 42. According to Patient 4's medical record, on or about February 18, 2021, a single-page
27 largely yes/no form document titled "Good Faith Exam" was filled out and signed with an
28 illegible signature and no printed name of the medical provider. No other medical examination,

1 patient medical history, physical examination, treatment or assessment plans were documented in
2 Patient 4's medical records. The GFE was not counter-signed by the Respondent and there was no
3 documented indication within the GFE that it was reviewed by Respondent. The "Patient History"
4 section of the GFE consisted of eight (8) check-mark boxes next to eight medical conditions, of
5 which all eight boxes were checked with the word "no" next to them. The GFE had a "Physical
6 Exam" section that consisted of two yes/no questions, a space for notes regarding asymmetries,
7 and a space to list facial scars, melisma, blemishes, and lesions. The spaces on the GFE denoting
8 the patient's weight, height, blood pressure, and heart rate were blank. The "Cosmetic
9 Evaluation" section of the GFE consisted of ten check-mark boxes, of which only four boxes
10 were checked. At the bottom of the single-page GFE was a listing of approximately thirty (30)
11 cosmetic treatments and procedures with check-mark boxes next to each one that indicate
12 approval or "clearance" for the patient to receive or not the treatment or procedure, of which
13 Patient 4 was "cleared" to receive almost all of the procedures. No specific evaluation,
14 assessment, or treatment plan of Patient 4 was documented as each of the approved cosmetic
15 procedures.

16 43. Patient 4's EuroPhoria medical record contains three sets of photographs of Patient 4
17 dated February 18, 2021, August 31, 2021, and November 1, 2021. Each set of photographs
18 depicted Patient 4 with marked dots on her face and consisted of between three to five
19 photographs for each date. No additional identifying information was provided with the
20 photographs other than the typed date and Patient 4's name at the top of each page. There was
21 no indication documented in Patient 4's EuroPhoria medical record as to who placed the marked
22 dots on her face or who took the photographs on any given date.

23 44. Patient 4's EuroPhoria medical records contained one page of text/chat dialogue
24 screenshots that indicated Patient 4 underwent Xeomin treatments on February 18, 2021, August
25 31, 2021, and November 1, 2021. Patient 4's name, date of birth, medical record number, or any
26 other identifiers were not documented in any of the individual text/chat dialogue screenshots.
27 The typed name of a EuroPhoria's registered nurse appeared under each date within each
28 screenshot without identifying what function they performed as to each treatment procedure.

1 While each screenshot stated "Xeomin" with a series of stated facial locations and corresponding
2 numerical values next to them, the exact botulinum toxin was not identified, nor was the lot
3 number, expiration date, or units of measurement used. Each screenshot concluded in the same
4 manner by stating that "post care instructions given" but does not state what the instructions were,
5 to whom they were given, and no additional information was documented in the screenshot. None
6 of these screenshots indicated that Respondent was consulted, reviewed and/or administered any
7 of the treatments of Patient 4. No specific evaluation, assessment or treatment plan of Patient 4
8 was documented in any of the screenshots.

9 **Patient 5**

10 45. Patient 5, a 48-year-old male patient, received cosmetic treatments at EuroPhoria
11 beginning in early-2021 consisting of Xeomin injections, Vanquish treatments, laser hair removal
12 (LHR), and miraDry⁷ treatments.

13 46. On or about April 29, 2021 and June 21, 2022, Patient 5 signed a document titled
14 "Treatment Consent Form" regarding the miraDry treatment. The documents were not co-signed
15 by Respondent or any representative of EuroPhoria, nor were Respondent or EuroPhoria
16 mentioned in the documents. There was no indication in the document that it was reviewed with
17 Patient 5 to determine Patient 5's competency, verification that he was adequately informed, and
18 not coerced. The document contained four bulleted sentences regarding the side effects and risks
19 of the treatment. The document also contained six yes/no medical condition questions posed to
20 Patient 5, none of which were answered in either document.

21 47. On or about April 29, 2021, Patient 5 filled out and signed a two-page EuroPhoria
22 form document titled "Client Information & Medical History" as well as a questionnaire. Neither
23 document was co-signed by Respondent or any representative of EuroPhoria, nor was there any
24 indication in the medical record that they were reviewed with Patient 5. The sections of the
25 document for the physical exam and cosmetic evaluation were blank and crossed out. Under the
26 section of medical history, Patient 5 indicated he was under the care of a physician, was taking

27 ⁷The miraDry treatment uses electromagnetic and thermal energy to reduce the number of
28 underarm sweat and odor glands, and treat excessive sweating and odor (axillary hyperhidrosis).

1 the medication Metformin⁸, and suffered from diabetes, high blood pressure, and asthma. Neither
2 the basis of Patient 5's office visit nor Patient 5's chief complaint were articulated or stated in the
3 medical record. There was no documentation in Patient 5's medical history regarding the use of
4 topical, injectable, or oral medications used to treat hyperhidrosis. There was no indication in
5 Patient 5's medical records regarding the potential causes of hyperhidrosis, a discussion of
6 various treatment options, or potential contraindications to miraDry treatment.

7 48. According to Patient 5's medical record, on or about April 29, 2021, a single-page
8 largely yes/no form document titled "Good Faith Exam" was filled out and signed with an
9 illegible signature and no printed name of the medical provider. The bottom of the document
10 contained a stamp with the identifying information of a EuroPhoria physician assistant. No other
11 medical examination, patient medical history, physical examination, treatment or assessment
12 plans were documented in Patient 5's medical record. The GFE was not counter-signed by
13 Respondent and there was no documented indication within the GFE that it was reviewed by
14 Respondent. The "Patient History" section of the GFE consisted of eight (8) check-mark boxes
15 next to eight medical conditions, of which all eight boxes were checked with the word "no" next
16 to them, in addition to the hand written word "diabetes" and a line through the box next to it.
17 There was no documentation in Patient 5's medical history in the GFE regarding the use of
18 topical, injectable, or oral medications used to treat hyperhidrosis. The GFE had a "Physical
19 Exam" section that consisted of two yes/no questions, a space for notes regarding asymmetries,
20 and a space to list facial scars, melisma, blemishes, and lesions. The spaces on the GFE denoting
21 Patient 5's weight, height, blood pressure, and heart rate were blank. The "Cosmetic Evaluation"
22 section of the GFE consisted of ten check-mark boxes, of which only five boxes were checked. At
23 the bottom of the single-page GFE was a listing of approximately thirty (30) cosmetic treatments
24 and procedures with check-mark boxes next to each one that indicate approval or "clearance" for
25 the patient to receive or not the treatment or procedure, of which Patient 5 was "cleared" to
26 receive thirteen (13) of the procedures. No specific evaluation, assessment, or treatment plan of
27 Patient 5 was documented as to each of the approved cosmetic procedures.

28 ⁸ Metformin is used in patients with type 2 diabetes to control high blood sugar.

49. Patient 5's EuroPhoria medical records contained three pages of text/chat dialogue screenshots that indicated Patient 5 underwent miraDry treatments on July 14, 2021 and June 21, 2022; Vanquish treatments on July 14, 2021, July 21, 2021, July 28, 2021, and August 12, 2021; LHR treatments on August 16, 2021, November 4, 2021, and January 17, 2022; and Xeomin treatment on October 20, 2021. Patient 5's name, date of birth, medical record number, or any other identifiers were not documented in any of the individual text/chat dialogue screenshots. The typed name of a EuroPhoria's registered nurse appeared under each date within each screenshot without identifying what function they performed as to each treatment procedure. While each screenshot stated "Miradry," no formula for creating the tumescent mixture was clearly documented. None of these screenshots indicated that Respondent was consulted, reviewed and/or administered any of the treatments to Patient 5. No specific evaluation, assessment or treatment plan of Patient 5 was documented in the medical record. The most recent screenshot was dated June 22, 2022 and it stated, "I, Uma M. Rao, M.D. have reviewed the forms, photos and plan for this patient. I agree with the medical record/treatment plan as stated. I do hereby attest that this information is true, accurate and complete to the best of my knowledge."

50. There is no documented indication that Respondent received or completed any formal training regarding the miraDry procedure.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

51. Respondent Uma Malempati Rao, M.D. has subjected her Physician's and Surgeon's Certificate No. A 78409 to disciplinary action under section 2234, subdivision (b), of the Code, and Title 16, California Code of Regulations sections 1399.541 and 1399.545, in that she committed gross negligence during the care and treatment of Patients 1, 2, 3 4, and 5. The circumstances are set forth in paragraphs 14 through 50, and those paragraphs are incorporated by reference as if fully set forth herein.

52. Respondent's license is subject to disciplinary action because she, and the mid-level providers she was supervising, committed gross negligence during the care and treatment of Patients 1, 2, 3, 4 and 5 in the following distinct and separate ways:

- 1 a. By failing to properly provide adequate supervision and oversight to mid-level
2 practitioners who provided treatment and care to Patients 1, 2, 3, 4, and 5;
3 b. By failing to properly create and maintain adequate and accurate medical records for
4 Patients 1, 2, 3, 4, and 5; and
5 c. By supervising and managing mid-level providers in the miraDry procedure without
6 herself obtaining any formal training in that procedure.

7 **SECOND CAUSE FOR DISCIPLINE**

8 **(Repeated Negligent Acts)**

9 53. Respondent Uma Malempati Rao, M.D. has further subjected her Physician's and
10 Surgeon's Certificate No. A 78409 to disciplinary action under section 2234, subdivision (c), of
11 the Code, and Title 16, California Code of Regulations sections 1399.541 and 1399.545, in that
12 she, and the mid-level providers she was supervising, committed repeated negligent acts during
13 the care and treatment of Patients 1, 2, 3, 4 and 5. The circumstances are set forth in paragraphs
14 14 through 52, and those paragraphs are incorporated by reference as if fully set forth herein.

15 54. Respondent committed the following negligent acts during the care and treatment of
16 Patients 1, 2, and 5:

- 17 a. By failing to properly obtain and document Patient 1's complete medical history prior
18 to performing cosmetic procedures;
19 b. By failing to properly conduct and document Patient 1's physical examination prior to
20 performing cosmetic procedures;
21 c. By failing to properly obtain and document Patient 1's informed consent prior to
22 performing each cosmetic procedure;
23 d. By failing to properly conduct and document Patient 2's physical examination prior to
24 performing cosmetic procedures; and
25 e. By failing to properly obtain and document Patient 5's relevant medical history and
26 chief complaint prior to performing cosmetic procedures.

27 ///

28 ///

1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Failure To Maintain Adequate And Accurate Records)**


3 55. Respondent Uma Malempati Rao, M.D. has further subjected her Physician's and
4 Surgeon's Certificate No. A 78409 to disciplinary action under section 2266 of Code, and Title
5 16, California Code of Regulations sections 1399.541 and 1399.545, in that she, and the mid-level
6 providers she was supervising, failed to maintain adequate and accurate medical records for
7 Patients 1, 2, 3, 4, and 5. The circumstances are set forth in paragraphs 14 through 50, and those
8 paragraphs are incorporated by reference as if fully set forth herein.

9 **PRAYER**

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

- 12 1. Revoking or suspending Physician's and Surgeon's Certificate No. A 78409, issued
13 to Uma Malempati Rao, M.D.;
- 14 2. Revoking, suspending or denying approval of Uma Malempati Rao, M.D.'s authority
15 to supervise physician assistants and advanced practice nurses;
- 16 3. Ordering Uma Malempati Rao, M.D., to pay the Board the costs of the investigation
17 and enforcement of this case, and if placed on probation, the costs of probation monitoring; and
- 18 4. Taking such other and further action as deemed necessary and proper.

19
20 DATED: NOV 10 2022

21 
22 WILLIAM PRASANNA
23 Executive Director
24 Medical Board of California
25 Department of Consumer Affairs
26 State of California
27 Complainant
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