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

In the Matter of the First Amended Accusation Against:	)	
Martin Edwin Kernberg, M.D.	)	**Case No. 800-2016-024134**
Physician's and Surgeon's Certificate No. G 62629	)	
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 November 8, 2019.

IT IS SO ORDERED: October 10, 2019.

MEDICAL BOARD OF CALIFORNIA

By: _____
Ronald H. Lewis, M.D., Chair
Panel A

XAVIER BECERRA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
GREG W. CHAMBERS
Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **Martin Edwin Kernberg, M.D.** **1327 Waller Street** **San Francisco, CA 94117** **Physician's and Surgeon's Certificate No. G 62629,** Respondent.	Case No. 800-2016-024134 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Greg W. Chambers, Deputy Attorney General.

2. Respondent Martin Edwin Kernberg, M.D. (Respondent) is represented in this proceeding by attorney James J. Zenere, whose address is: 1033 Willow Street, San Jose, CA 95125.

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JURISDICTION

3. On or about April 11, 1988, the Board issued Physician's and Surgeon's Certificate No. G 62629 to Martin Edwin Kernberg, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2016-024134, and will expire on November 30, 2019, unless renewed.

4. Accusation No. 800-2016-024134 was filed before the Board, and was properly served on Respondent on April 26, 2018, along with all other statutorily required documents. Respondent timely filed his Notice of Defense contesting the Accusation. A First Amended Accusation was subsequently filed and served and is currently pending against Respondent.

5. A copy of First Amended Accusation No. 800-2016-024134 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2016-024134. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent admits the truth of each and every charge and allegation in First Amended Accusation No. 800-2016-024134.

10. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

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

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

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 62629 issued to Respondent Martin Edwin Kernberg, M.D. shall be and hereby is publicly reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This

public reprimand is issued in connection with Respondent's failure to maintain accurate and adequate records, as set forth in First Amended Accusation No. 800-2016-024134.

B. MEDICAL RECORD KEEPING COURSE

Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine ("Medical Record Keeping Program"), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education ("CME") requirements for renewal of licensure.

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

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

If Respondent fails to enroll in or successfully complete the medical record keeping course within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until he as completed the medical record keeping course. Failure to enroll in or successfully complete the medical record keeping course course within the designated time period shall constitute unprofessional conduct and grounds for

further disciplinary action.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, James J. Zenere. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 9/3/2019

MARTIN EDWIN KERNBERG, M.D.
Respondent

I have read and fully discussed with Respondent Martin Edwin Kernberg, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 9/3/19

JAMES J. ZENERE
Attorney for Respondent

ENDORSEMENT

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

DATED: 9/4/2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General

GREG W. CHAMBERS
Deputy Attorney General
Attorneys for Complainant

Exhibit A

First Amended Accusation No. 800-2016-024134

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
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In the Matter of the First Amended Accusation Against: **Martin Edwin Kernberg, M.D.** **1327 Waller Street** **San Francisco, CA 94117** **Physician's and Surgeon's Certificate No. G 62629,** Respondent.	Case No. 800-2016-024134 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about April 11, 1988, the Medical Board issued Physician's and Surgeon's Certificate Number G 62629 to Martin Edwin Kernberg, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2019, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Business and Professions Code authorizes the Board to take action against a licensee by revoking, suspending for a period not to exceed one year, placing the license on probation and requiring payment of costs of probation monitoring, or taking such other action taken as the Board deems proper.

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

FIRST CAUSE FOR DISCIPLINE

(Inadequate Medical Record Keeping in the care provided to Patient CS) [1]

6. Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records for Patient CS. The circumstances are as follows:

7. From on or about July 25, 2015, through January 4, 2017, Respondent treated Patient CS for chronic back pain. The patient had a history of work-related thoraco-lumbar injury, chronic fatigue and fibromyalgia, thoracic tumor and thoracalgia, neuralgia, neuritis, and radiculitis, pneumonia, and left middle finger fracture.

8. Within the records for Patient CS, the "Differential Diagnosis" section identified on practically every clinic visit was the same or similar. The body of the text was as follows:

> "Differential diagnosis of syncope: thoracic outlet syndrome, vasovagal syndrome, and orthostatic hypotension. Differential diagnosis of extremity pain includes fracture, subluxation, dislocation; contusion, hematoma, or laceration; muscle, ligaments, and tendons sprain, partial or complete terror; infection, inflammation, or immunological reaction; vascular injury, including atherosclerotic disease, thromboembolic occlusion, aneurysm, rupture, or dissection; or other neurologic disorder. The differential

[1] Patient initials are used to protect their privacy. Respondent may learn the names of the patients through the discovery process.

diagnosis for this chief complaint is reviewed in the corresponding section of the written chart, with the appropriate investigational studies listed in the orders."

9. Within the records for Patient CS, the "laboratory data" section on practically every clinic visit was the same or similar. The body of the text was as follows:

"Principal abnormalities are noted. The previously obtained laboratory and/or radiology data is reviewed in the written chart and laboratory and/or radiology printouts, with appropriate designation of those studies still pending at the time of dictation. Additional radiographic studies are reviewed in the written chart, facsimile reports from radiology, and in the radiology final reports."

10. In the section identified as the "Clinic Course" on practically every clinic visit was the same or similar. The body of the text was as follows:

"History and physical examination were performed and the diagnostic test noted below ordered, pending, or reviewed. Details of the medications (reviewed in medication section) prescribed are in the digital and/or written chart. Radiologic, neurosurgical, orthopedic and/or psychological consultations were recommended (as noted below). The patient understood the treatment plan, and ***was discharged in stable condition***. Verbal and, as appropriate, written discharge instructions and/or written prescriptions were given, with detailed criteria for return to the clinic. Follow up with the clinic and associated consultants was recommended." (Emphasis added.)

11. Respondent failed to keep adequate and accurate medical records.

SECOND CAUSE FOR DISCIPLINE

(Inadequate Medical Record Keeping in the care provided to Patient SM)

12. Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records for Patient SM. The circumstances are as follows:

13. On or about July 5, 2014, through January 24, 2017, patient SM was seen by Respondent for back pain. The patient had a history of Legg-Calve-Perthes, secondary osteoarthritis of left hip, lumbar discopathy (L1,2,3), partial amputation of his left foot from a lawn mower injury, left boxer fracture, cholecystectomy and atrial fibrillation with ablation.

14. Within the records for Patient SM, the "Differential Diagnosis" section identified on practically every clinic visit was the same or similar. The body of the text was as follows:

"Differential diagnosis of extremity pain includes fracture, subluxation, dislocation; contusion, hematoma, or lacerations; muscle, ligament, and tendon strain, partial or complete tear; infection, inflammation, or immunologic reaction; vascular injury, including atherosclerotic disease, thromboembolic occlusion, aneurysm, rupture, or dissection; or other neurologic disorder. The differential diagnosis for the chief complaint is reviewed in the corresponding section of the written chart, with the appropriate investigational studies listed in the orders."

15. Within the records for Patient SM, the "laboratory data" section on practically every clinic visit was the same or similar. The body of the text was as follows:

"Laboratory data: Principal abnormalities are noted. The remainder of the negative, obtained laboratory and/or radiology data is reviewed in the written chart and laboratory printouts, with appropriate designation of those studies still pending at the time of dictation. Additional radiologic studies are reviewed in the written chart, facsimile reports from radiology, and in the radiology final reports."

16. Within the records for Patient SM, the "Clinic Course" section for practically every clinic visit was the same or similar. The body of the text was as follows:

"History and physical examination were performed and the laboratory noted above ordered. Monitoring of hemodynamics, electrocardiographic and pulmonary oximetry data was initiated. Details of the medications prescribed are in the medication list, digital and/or written chart. Details of the medications prescribed are in the written chart. Urgent radiologic and orthopedic consultations were recommended. ***The patient responded to the treatment, and was discharged in stable condition.*** Printed discharge instructions and prescriptions were given, with detailed criteria for return to the clinic. Follow-up with the Clinic and associated consultants was recommended." (Emphasis added.)

17. Respondent failed to keep adequate and accurate medical records.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Medical Record Keeping in the care provided to Patient JN)

18. Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records for Patient JN. The circumstances are as follows:

19. From on or about March 30, 2013, through April 15, 2016, Respondent treated Patient JN for acute spine and lower extremity pain. The patient also had a history of myocardial infarction, seizures, bleeding ulcers, tobacco use, depression attributed to wife's death, and chronic right ankle pain after surgery.

20. Within the records for Patient JN, the "Differential Diagnosis" section identified on practically every clinic visit was the same or similar. The body of the text was as follows:

> "Differential diagnosis of lower extremity pain includes fracture, subluxation, dislocation; contusion, hematoma, or lacerations; muscle, ligament, and tendon strain, partial or complete tear; infection, inflammation, or immunologic reaction; vascular injury, including atherosclerotic disease, thromboembolic occlusion, aneurysm, rupture, or dissection; or other neurologic disorder. The differential diagnosis for the chief complaint is reviewed in the corresponding section of the written chart, with the appropriate investigational studies listed in the orders."

21. Within the records for Patient JN, the "laboratory data" section on practically every clinic visit was the same or similar. The body of the text was as follows:

> "Laboratory data: Principal abnormalities are noted. The remainder of the negative, obtained laboratory data (including CBC with differential counts, chemistry 7, calcium, magnesium, and phosphorus, urinalysis, urine drug screen, prothrombin, partial thromboplastin, INR, type and screen, ECG, chest radiograph, and lower extremity radiograph), is reviewed in the written chart and laboratory printouts, with appropriate designation of those studies still pending at the time of dictation. Additional radiographic studies are reviewed in the written chart, facsimile reports from radiology, and in the radiology final reports."

22. Within the records for Patient JN, the "Clinic Course" section for practically every clinic visit was the same or similar. The body of the text was as follows:

> "History and physical examination were performed and the laboratory noted above ordered. Monitoring of hemodynamics, electrocardiography and pulmonary symmetry data was initiated. Details of the medications prescribed are in the written chart. Urgent radiographic and orthopedic consultations were recommended. ***The patient responded to the treatment, and was discharged in stable condition.*** Printed discharge instructions and prescriptions were given, with detailed criteria for return to the clinic. Follow-up with the clinic and associated consultants was recommended." (Emphasis added.)

23. Respondent failed to maintain complete and accurate medical records.

FOURTH CAUSE FOR DISCIPLINE

(Inadequate Medical Record Keeping in the care provided to Patient SW)

24. Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records for Patient SW. The circumstances are as follows:

25. From on or about July 20, 2013, through June 21, 2016, Respondent treated Patient SW, who suffered from chronic back pain dating back to 1997. The patient had a history of spinal fusion of L4 to S1 after an industrial accident, revision of the spinal fusion at L4-5, and sacroiliac joint fusion.

26. Within the records for Patient SW, the "Differential Diagnosis" section identified on practically every clinic visit was the same or similar. The body of the text was as follows:

> Differential diagnosis of extremity pain includes fracture, subluxation, dislocation; contusion, hematoma, or lacerations; muscle, ligament, and tendon strain, partial or complete tear; infection, inflammation, or immunologic reaction; vascular injury, including atherosclerotic disease, thromboembolic occlusion, aneurysm, rupture, or dissection; or other neurologic disorder. The differential diagnosis for the chief complaint is reviewed in the corresponding section of the written chart, with the appropriate investigational studies listed in the orders."

27. Within the records for Patient SW, the "laboratory data" section on practically every clinic visit was the same or similar. The body of the text was as follows:

> "Laboratory data: principal abnormalities are noted. The previously obtained laboratory and/or radiology data is reviewed in the written chart and laboratory and/or radiology printouts, with appropriate designation of those studies still pending at the time of dictation. Additional radiologic studies are reviewed in the written chart, facsimile reports from radiology, and in the radiology final reports."

28. Within the records for Patient SW, the "Clinic Course" section for practically every clinic visit was the same or similar. The body of the text was as follows:

> "History and physical examination were performed and the diagnostic test noted below ordered. Monitoring of hemodynamics, electrocardiography and pulmonary symmetry data was initiated. Details of the medications prescribed are in the medication list, digital and/or written chart. Radiologic, neurosurgical, orthopedic and / or psychological consultations were recommended (as noted below). ***The patient understood the treatment plan, and was discharged in stable condition.*** Verbal and, as appropriate, written discharge instructions and/or written prescriptions were given, with detailed criteria for return to the clinic. Follow-up with the Clinic and associated consultants was recommended." (Emphasis added.)

29. Respondent's medical records of Patient SW were not accurate and complete.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 62629, issued to Martin Edwin Kernberg, M.D.;

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

3. Ordering Martin Edwin Kernberg, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: September 3, 2019

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