

**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. )  
)  
Physician's and Surgeon's )  
Certificate No. G 62629 )  
)  
Respondent )**

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**Case No. 800-2016-024134**

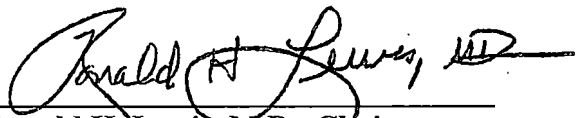
**DECISION**

**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

1 XAVIER BECERRA  
Attorney General of California  
2 MARY CAIN-SIMON  
Supervising Deputy Attorney General  
3 GREG W. CHAMBERS  
Deputy Attorney General  
4 State Bar No. 237509  
455 Golden Gate Avenue, Suite 11000  
5 San Francisco, CA 94102-7004  
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6 Facsimile: (415) 703-5480  
*Attorneys for Complainant*

7  
8 **BEFORE THE**  
**MEDICAL BOARD OF CALIFORNIA**  
9 **DEPARTMENT OF CONSUMER AFFAIRS**  
**STATE OF CALIFORNIA**

10 In the Matter of the First Amended Accusation  
11 Against:

Case No. 800-2016-024134

12 **Martin Edwin Kernberg, M.D.**  
13 **1327 Waller Street**  
**San Francisco, CA 94117**

**STIPULATED SETTLEMENT AND  
DISCIPLINARY ORDER**

14 **Physician's and Surgeon's Certificate**  
15 **No. G 62629,**

16 Respondent.

17  
18 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-  
19 entitled proceedings that the following matters are true:

20 **PARTIES**

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

25 2. Respondent Martin Edwin Kernberg, M.D. (Respondent) is represented in this  
26 proceeding by attorney James J. Zenere, whose address is: 1033 Willow Street, San Jose, CA  
27 95125.

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1 **JURISDICTION**

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

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

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

13 **ADVISEMENT AND WAIVERS**

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

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

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

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1 **CULPABILITY**

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

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

7 **CONTINGENCY**

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

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

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

24 **DISCIPLINARY ORDER**

25 **A. PUBLIC REPRIMAND**

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

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

3 **B. MEDICAL RECORD KEEPING COURSE**

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

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

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

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

1 further disciplinary action.

2 ACCEPTANCE

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

8 DATED: 9/3/2019 Mate Edwin Kernberg  
9 MARTIN EDWIN KERNBERG, M.D.  
10 Respondent

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

14 DATED: 9/3/19 [Signature]  
15 JAMES J. ZENERE  
16 Attorney for Respondent

17 ENDORSEMENT

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

20 DATED: 9/4/2019

21 Respectfully submitted,  
22 XAVIER BECERRA  
23 Attorney General of California  
24 MARY CAIN-SIMON  
25 Supervising Deputy Attorney General

26 [Signature]  
27 GREG W. CHAMBERS  
28 Deputy Attorney General  
Attorneys for Complainant

**Exhibit A**

**First Amended Accusation No. 800-2016-024134**

1 XAVIER BECERRA  
Attorney General of California  
2 MARY CAIN-SIMON  
Supervising Deputy Attorney General  
3 GREG W. CHAMBERS  
Deputy Attorney General  
4 State Bar No. 237509  
455 Golden Gate Avenue, Suite 11000  
5 San Francisco, CA 94102-7004  
Telephone: (415) 510-3382  
6 Facsimile: (415) 703-5480  
*Attorneys for Complainant*

FILED  
STATE OF CALIFORNIA  
MEDICAL BOARD OF CALIFORNIA  
SACRAMENTO Sept 3 2019  
BY: [Signature] ANALYST

7  
8 **BEFORE THE**  
9 **MEDICAL BOARD OF CALIFORNIA**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the First Amended Accusation  
13 Against:

Case No. 800-2016-024134

14 **Martin Edwin Kernberg, M.D.**  
15 **1327 Waller Street**  
16 **San Francisco, CA 94117**

**FIRST AMENDED ACCUSATION**

17 **Physician's and Surgeon's Certificate**  
18 **No. G 62629,**

Respondent.

19 Complainant alleges:

**PARTIES**

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

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

27 ///

28 ///



1 **JURISDICTION**

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

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

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

12 **FIRST CAUSE FOR DISCIPLINE**

13 (Inadequate Medical Record Keeping in the care provided to Patient CS)<sup>1</sup>

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

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

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

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

27 <sup>1</sup> Patient initials are used to protect their privacy. Respondent may learn the names of the  
28 patients through the discovery process.

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

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

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

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

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

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

### 24 SECOND CAUSE FOR DISCIPLINE

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

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

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

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

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

9  
10  
11 15. Within the records for Patient SM, the "laboratory data" section on practically every  
12 clinic visit was the same or similar. The body of the text was as follows:

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

19  
20  
21 16. Within the records for Patient SM, the "Clinic Course" section for practically every  
22 clinic visit was the same or similar. The body of the text was as follows:

23 "History and physical examination were performed and the laboratory noted  
24 above ordered. Monitoring of hemodynamics, electrocardiographic and  
25 pulmonary oximetry data was initiated. Details of the medications prescribed  
26 are in the medication list, digital and/or written chart. Details of the  
27 medications prescribed are in the written chart. Urgent radiologic and  
28 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)

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

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

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

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

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

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

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

24 "History and physical examination were performed and the laboratory noted  
25 above ordered. Monitoring of hemodynamics, electrocardiography and  
26 pulmonary symmetry data was initiated. Details of the medications  
27 prescribed are in the written chart. Urgent radiographic and orthopedic  
28 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.)

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

#### 30 FOURTH CAUSE FOR DISCIPLINE

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

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

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

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

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

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

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

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

25           "History and physical examination were performed and the diagnostic test  
26 noted below ordered. Monitoring of hemodynamics, electrocardiography and  
27 pulmonary symmetry data was initiated. Details of the medications  
28 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*