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

In the Matter of the Accusation Against: Jen-Kway Shen, M.D. Physician's & Surgeon's Certificate No A44321 Respondent	Case No. 800-2018-043479

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 March 3, 2021.

IT IS SO ORDERED February 1, 2021.

MEDICAL BOARD OF CALIFORNIA

By: Kristina Lawson

Kristina D. Lawson, J.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
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Attorneys for Complainant

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

In the Matter of the Accusation Against: JEN-KWAY SHEN, M.D. 1629 Sialic Place La Habra Heights, CA 90631 Physician's and Surgeon's Certificate No. A 44321, Respondent.	Case No. 800-2018-043479 **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. William Prasifka ("Complainant") is the Executive Director of the Medical Board of California ("Board"). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Rebecca L. Smith, Deputy Attorney General.

1. Jen-Kway Shen, M.D. ("Respondent") is represented in this proceeding by attorney Robert B. Packer, whose address is 505 North Brand Boulevard, Suite 1025, Glendale, California 91203.

2. On or about December 14, 1987, the Board issued Physician's and Surgeon's Certificate No. A 44321 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2018-043479 and will expire on January 31, 2021, unless renewed.

JURISDICTION

2. Accusation No. 800-2018-043479 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 29, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

3. A copy of Accusation No. 800-2018-043479 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

4. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-043479. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

7. Respondent understands that the charges and allegations in Accusation No. 800-2018-043479, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

8. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges and agrees to be bound by the imposition of discipline by the Board as set forth in the Disciplinary Order below.

CONTINGENCY

9. 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.

10. 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.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 44321 issued to Respondent Jen-Kway Shen, M.D. is publicly reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4), with the following attendant terms and conditions.

A. PUBLIC REPRIMAND.

This Public Reprimand, which is issued in connection with Respondent's care and treatment of Patient 1 as set forth in Accusation No. 800-2018-043479, is as follows:

> In 2013, you committed acts constituting negligence in violation of Business and Professions Code section 2234, subdivisions (b) and (c), in your care and treatment of Patient 1, by failing to document a discussion of the risks and benefits of an elective Pitocin induction and timely recognize and treat Patient 1's severe blood loss following delivery.

B. EDUCATION COURSE.

Within sixty (60) calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than twenty (20) hours. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education ("CME") requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for twenty (20) hours of CME in satisfaction of this condition.

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 educational program(s) or course(s), or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

If Respondent fails to enroll, participate in, or successfully complete the educational program(s) or course(s) 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 enrollment or participation in the educational program(s) or course(s) has been completed. Failure to successfully complete the educational program(s) or course(s) outlined above shall constitute

unprofessional conduct and is 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, Robert B. Packer. 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: 12/20/2020

JEN-KWAY SHEN, M.D.
Respondent

I have read and fully discussed with Respondent Jen-Kway Shen, 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: 12/23/2020

ROBERT B. PACKER
Attorney for Respondent

ENDORSEMENT

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

DATED: 12/23/2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2018-043479

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Attorneys for Complainant

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

In the Matter of the Accusation Against:	Case No. 800-2018-043479
JEN-KWAY SHEN, M.D. 1629 Sialic Place La Habra Heights, California 90631-8088 Physician's and Surgeon's Certificate No. A 44321, Respondent.	**ACCUSATION**

PARTIES

1. Christine J. Lally ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about December 14, 1987, the Medical Board issued Physician's and Surgeon's Certificate Number A 44321 to Jen-Kway Shen, M.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2021, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

5. Section 2227 of the Code states:

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

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

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

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

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

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

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

6. 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.

7. 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.

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FACTUAL ALLEGATIONS

8. Patient 1,[1] a then 33-year-old gravida 2, para 1 woman, arrived in California from China on February 20, 2013, in the late second/early third trimester of her pregnancy. She sought obstetrical care with Respondent on February 25, 2013, at which time she was approximately 27-weeks gestation with an estimated date of delivery of May 28, 2013. Patient 1 provided Respondent with some prenatal records from China, including an ultrasound performed on February 15, 2013, consistent with 25-weeks, 2-days gestation. Patient 1 saw Respondent for prenatal care approximately every two weeks for the next three months during which time, Respondent documented the progress of Patient 1's pregnancy, including blood pressure readings and laboratory studies. On April 26, 2013, Respondent diagnosed Patient 1 with gestational diabetes. He documented that he instructed her on diet, exercise and blood sugar monitoring and that she refused blood sugar monitoring treatment.

9. On May 20, 2013, Patient 1 presented to Respondent's office complaining of contractions. Respondent performed a cervical examination which revealed that Patient 1 was one centimeter dilated, 80% effaced and at minus one station. Respondent stated that Patient 1 requested an induction of labor in order to hasten her return to China. He suggested that the patient wait until she passed her due date to be induced, but did not advise against induction at that time. The patient's request for induction and Respondent's recommendation to wait was not documented nor was there any documentation of any discussion with the patient regarding the risks associated with induction of labor.

10. On May 21, 2013 at 8:24 a.m., Patient 1 presented to PIH Health Hospital in Whittier (hereinafter referred to as "hospital") for induction of labor at 39-weeks gestation. Respondent admitted the patient to labor and delivery and gave telephonic admission orders at approximately 9:25 a.m., including the administration of intravenous Pitocin.[2] There was no documentation of any discussion between Respondent and Patient 1 of the risks and benefits of an elective Pitocin induction. Pitocin was started at 10:32 a.m. From 7:00 p.m. to 8:24 p.m., Patient 1's pain level

[1] For privacy purposes, the patient in this Accusation is referred to as Patient 1.

[2] Pitocin is a medication that causes the uterus to contract and is used to induce labor.

induction. Pitocin was started at 10:32 a.m. From 7:00 p.m. to 8:24 p.m., Patient 1's pain level was noted to have increased from 4 out of 10 to 8 out of 10. A cervical examination was performed at 8:28 p.m. at which time Patient 1 was noted to be 1.5 cm dilated, 80% effaced and at minus two station. At 8:55 p.m., the patient's blood pressure was 121/73, heart rate was 93 and oxygen saturation rate was 98%. At 9:20 p.m., a cervical examination revealed that the patient was 4.5 cm dilated, 90% effaced and at minus one station; the Pitocin was turned off. Deep variable fetal decelerations developed at approximately 9:32 p.m. and a Category III Fetal Heart Rate tracing was noted.[3] At 9:39 p.m., the patient had a spontaneous rupture of membranes with scant clear fluid prior noted at 9:36 p.m. A cervical examination revealed that the patient was 10 cm dilated and at station one. Anesthesiologist, Dr. S.L. was notified of the patient's request for an epidural and at 9:40 p.m., Respondent was notified of the patient's status. The hospital's resident physician, Dr. P.M., was at the patient's bedside. Crowning was noted at 9:54 p.m. and a male infant weighing 3,175 grams was delivered at 9:56 p.m. by Dr. P.M. with APGARS of 9 at both 1 and 5 minutes. Both Dr. P.M. and Nurse R.S. documented that there was a large "gush of blood" during the delivery of the infant. An estimated blood loss of 2,100 cc was noted on the Delivery Report.

11. At 10:01 p.m., Respondent was present in the delivery room. At 10:02 p.m., the patient's blood pressure was 96/56 and pulse was 157. Respondent documented that he observed a normal amount of vaginal bleeding and the placenta, which was already separated, was delivered easily at 10:04 p.m. For 6 minutes following the delivery of the placenta, Respondent noted that the patient was slowly oozing blood. In response, he ordered Methergine and Pitocin to stop the uterine bleeding.

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[3] From approximately 8:53 p.m. to 9:00 p.m., the patient had a Category I fetal heart rate tracing. A Category I fetal heart rate tracing is normal and not associated with fetal asphyxia. A Category III fetal heart rate tracing is abnormal and indicative of hypoxic risk to the fetus.

12. Respondent ordered packed red blood cells at 10:15 p.m., Hemabate[4] at 10:17 p.m. and laboratory studies, including a DIC panel[5] at 10:18 p.m. He performed a bimanual examination and massage for uterine tone/bleeding. He placed the patient in a dorsolithotomy position and examined her perineum, vagina and cervix for lacerations. The patient's blood pressure was 54/31 and heart rate was 139 at 10:30 p.m. In further effort to control the postpartum bleeding, Respondent placed a Bakri balloon with ultrasound confirmation by obstetrician, Dr. P.R., who was called in to assist. Vaginal packing was done and the fundus was noted to be firm.

13. Anesthesiologist, Dr. S.L. arrived to the patient's bedside at 10:35 p.m. and began giving intravenous Neo-Synephrine in order to maintain an adequate blood pressure during anesthesia and for treatment of vascular failure, and Hespan to treat hypovolemia. The patient's blood pressure was 48/27 at 10:35 p.m., and 100/36 at 10:41 p.m. Two units of uncross-matched blood, O Negative, were in the room at 10:43 p.m. The patient's blood pressure was 81/46 at 10:45 p.m., 106/50 at 10:50 p.m. and 96/52 at 10:55 p.m. A second dose of Methergine and rectal Cytotec were given at 10:55 p.m. to stop the uterine bleeding. The patient's blood pressure was 82/45 at 11:01 p.m., 86/49 at 11:09 p.m. and 85/42 at 11:15 p.m.[6]

14. Following the administration of the rescue medications by Dr. S.L., Patient 1's peripheral capillary oxygen saturation was maintained at 100% and the bleeding appeared to be more controlled with systolic blood pressure improvement between 80 and 100. Rather than administer the two units of uncross-matched blood, the decision was made to wait for the cross-matched blood.[7] Dr. S.L. documented that it was anticipated that the cross-matched blood would

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[4] Hemabate is a medication administered to treat severe postpartum bleeding.

[5] Disseminated intravascular coagulation (DIC) is a condition in which blood clots form throughout the body, blocking small blood vessels. A DIC panel is a group of laboratory tests used to determine the presence of DIC.

[6] From 10:30 p.m. to 11:15 p.m., the patient's heart rate ranged between 131 to 151.

[7] Respondent stated that Dr. S.L. stopped the nurse from hanging the uncross-matched O Negative blood and there was no discussion regarding the decision to wait for cross-matched blood; however, Respondent also stated that he and Dr. S.L. jointly made the decision to wait for cross matched blood. There was no documentation in the medical records reflecting that Respondent did not participate in the decision to wait for the cross-matched blood.

be available in 30 minutes. Nursing documented that the cross-matched blood would be available in 10 minutes. Although not documented, Respondent stated that he believed the cross-matched blood would be available in 2 minutes. The first unit of cross-matched blood was administered at 11:20 p.m., 37 minutes after the uncross-matched blood was available, and the second unit was administered minutes later.

15. Nurse R.S. noted that the patient was pale, had labored respirations and a distended abdomen. Dr. S.L. also noted that the patient had become incoherent. Respondent stated that a nurse told him that she heard a "pop". Respondent documented that he observed Patient 1's abdomen distending and called for an exploratory laparotomy for a possible uterine rupture from the Bakri balloon. Estimated blood loss since he arrived to the patient's bedside was 900 cc. This was not documented however. The hospital's Rapid Response Team was present at the bedside at 11:21 p.m.

16. At 11:43 p.m., Patient 1 was taken to the operating room. Dr. S.L. performed a rapid sequence IV induction. Dr. S.L. was unable to intubate and called intensivist, Dr. N.C., who then successfully intubated the patient. At approximately 12:03 a.m. on May 22, 2013, the patient went into sinus tachycardia with no pulse. A Code Blue was called and the patient was successfully resuscitated. Respondent performed a supracervical hysterectomy. Bleeding was found in the left lower uterine segment and an extensive hematoma was found in the left adnexal area. During surgery, the abnormal results of the patient's DIC panel were reported to Respondent and the patient received multiple units of packed red blood cells. The Surgical Record of Operation reflected an estimated blood loss of 2,500 cc. Respondent's Operative Report noted that the estimated blood loss was undetermined.

17. Patient 1 was transferred to the ICU. At 4:13 a.m., a Code Blue was called. Patient 1 could not be resuscitated. She expired at 4:26 a.m. At autopsy, the coroner concluded that Patient 1 died of postpartum hemorrhage due to complications of a normal vaginal delivery and the manner of death was deemed natural.[8]

[8] The Autopsy Report did not show evidence of a uterine rupture, but there were findings of 300 cc of blood in the peritoneal cavity, 200 cc of blood in the right lung, 150 cc of blood in the left lung, and the heart had endocardial hemorrhages.

STANDARD OF CARE

18. In evaluating and managing a postpartum hemorrhage when the patient's prior blood loss cannot be easily ascertained (i.e., when there is internal bleeding, a blood loss that is not witnessed, or a blood loss that is not reported or measured easily), the standard of care requires that the obstetrician recognize that a collapse in vital signs (a pulse greater than 120 and systolic blood pressure of less than 90) does not present until the patient's blood loss is very substantial and requires that a transfusion of blood products be instituted as rapidly as possible. Managing the hemorrhage initially with aggressive transfusion ratio support should take place while establishing the source of hemorrhage and its subsequent treatment. Rapidly transfusing the first blood product available in a ratio form should take place immediately rather than waiting for cross-matched blood when there is significant blood loss, collapse in vital signs and continued oozing.

19. When an obstetrical patient is scheduled to undergo an elective Pitocin induction, the standard of care requires that the obstetrician discuss the risks and benefits of the procedure with the patient and document that discussion in the patient's medical records.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

20. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he committed gross negligence with respect to his care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 18, above, as though fully set forth herein. The circumstances are as follows:

21. Respondent failed to recognize the severity of Patient 1's blood loss and delayed transfusion by failing to use the uncross-matched O Negative blood that was available at 10:43 p.m. and waiting until 11:20 p.m. to start transfusing with cross-matched blood.

22. Respondent's acts and/or omissions as set forth in paragraphs 8 through 18 and 20 through 21, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

23. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts with respect to his care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 22, above, as though fully set forth herein.

24. In addition, Respondent was negligent in his care of Patient 1 when he failed to recognize the severity of Patient 1's blood loss and delayed transfusion by failing to use the uncross-matched O Negative blood that was available at 10:43 p.m. Respondent waited until 11:20 p.m. to start transfusing Patient 1 with cross-matched blood.

25. Respondent also failed to document in Patient 1's medical records that he discussed the risks and benefits of an elective Pitocin induction.

26. Respondent's acts and/or omissions as set forth in paragraphs 8 through 25, above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts pursuant to section 2234, subdivision (c), of the Code. Therefore, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

27. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate records concerning the care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates Paragraphs 9 through 10, 14 through 15, 19 and 25, above, as though set forth fully herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 44321, issued to Jen-Kway Shen, M.D.;

2. Revoking, suspending or denying approval of Jen-Kway Shen, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Jen-Kway Shen, 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: APR 29 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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