

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

In the Matter of the First Amended  
Accusation Against:

Manjula Bobbala, M.D.

Physician's & Surgeon's  
Certificate No A 87444

Respondent

Case No. 800-2018-041844


**DECISION AND ORDER**

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 February 23, 2022.

IT IS SO ORDERED January 24, 2022.

MEDICAL BOARD OF CALIFORNIA



---

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

1 ROB BONTA  
Attorney General of California  
2 STEVEN D. MUNI  
Supervising Deputy Attorney General  
3 JOHN S. GATSCHET  
Deputy Attorney General  
4 State Bar No. 244388  
California Department of Justice  
5 1300 I Street, Suite 125  
P.O. Box 944255  
6 Sacramento, CA 94244-2550  
Telephone: (916) 210-7546  
7 Facsimile: (916) 327-2247

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 First Amended Accusation Against:

Case No. 800-2018-041844

14 **MANJULA BOBBALA, M.D.**  
100 Prison Road  
15 Represa, CA 95671

OAH No. 2021020331

16 Physician's and Surgeon's Certificate No. A 87444,

**STIPULATED SETTLEMENT  
AND DISCIPLINARY ORDER**

17 Respondent.

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

21 **PARTIES**

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

26 2. Respondent Manjula Bobbala, M.D. ("Respondent") is represented in this proceeding  
27 by attorney Chrisman Swanberg, whose address is:  
28

1 Chrisman Swanberg  
2 CCHCS Office of Legal Affairs, Bldg D-3  
3 P.O. Box 588500  
4 Elk Grove CA, 95758

5 3. On or about June 4, 2004, the Board issued Physician's and Surgeon's Certificate No.  
6 A 87444 to Manjula Bobbala, M.D. ("Respondent"). That Certificate was in full force and effect  
7 at all times relevant to the charges brought in First Amended Accusation No. 800-2018-041844,  
8 and will expire on June 30, 2022, unless renewed.

9 **JURISDICTION**

10 4. First Amended Accusation No. 800-2018-041844 was filed before the Board, and is  
11 currently pending against Respondent. The First Amended Accusation and all other statutorily  
12 required documents were properly served on Respondent. Respondent waives the Statute of  
13 Limitations as it relates to the filing of a First Amended Accusation and hereby agrees that the  
14 original Accusation was properly filed on December 4, 2020. Respondent timely filed her Notice  
15 of Defense contesting both the Accusation and the First Amended Accusation.

16 5. A copy of the First Amended Accusation No. 800-2018-041844 is attached as exhibit  
17 A and incorporated herein by reference.

18 **ADVISEMENT AND WAIVERS**

19 6. Respondent has carefully read, fully discussed with counsel, and understands the  
20 charges and allegations in the First Amended Accusation No. 800-2018-041844. Respondent has  
21 also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated  
22 Settlement and Disciplinary Order.

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





1 Respondent shall successfully complete all coursework and provide proof of completion  
2 of the Medical Record Keeping Course to the Board within one year of the effective date of the  
3 Decision and Order. This condition shall be monitored by the Probation Department.

4 **C. FAILURE TO COMPLY**

5 If Respondent fails to enroll, participate in, or successfully complete the educational  
6 program(s) or course(s), described in conditions B and C, within the designated time period,  
7 Respondent shall receive and comply with a notification from the Board or its designee to cease  
8 the practice of medicine within three (3) calendar days after being so notified. Respondent shall  
9 not resume the practice of medicine until enrollment or participation in the educational  
10 program(s) or course(s) has been completed as required by the express language of the Decision  
11 and Order. In addition, failure to successfully complete the education program(s) or course(s)  
12 outlined above shall also constitute unprofessional conduct and is grounds for further immediate  
13 disciplinary action.

14 ///

15 ///

16 ///

17 ///

18 ///

19 ///

20 ///

21 ///

22 ///

23 ///

24 ///

25 ///

26 ///

27 ///

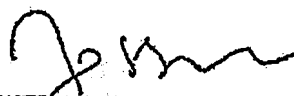
28 ///

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

ACCEPTANCE

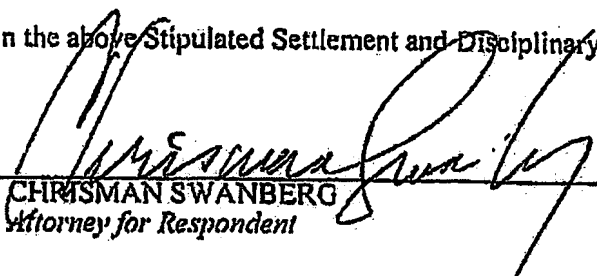
I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Chrisman Swanberg. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary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

DATED: 08/26/2021

  
\_\_\_\_\_  
MANJULA BOBBALA, M.D.  
*Respondent*

I have read and fully discussed with Respondent Manjula Bobbala, 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: 8/24/2021

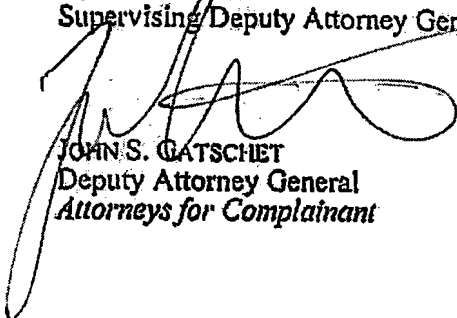
  
\_\_\_\_\_  
CHRISMAN SWANBERG  
*Attorney for Respondent*

ENDORSEMENT

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

DATED: 8-27-2021

Respectfully submitted,  
ROB BONTA  
Attorney General of California  
STEVEN D. MUNI  
Supervising Deputy Attorney General

  
\_\_\_\_\_  
JOHN S. GATSCHET  
Deputy Attorney General  
*Attorneys for Complainant*

SA2020303540  
35412298.docx

**Exhibit A**

**First Amended Accusation No. 800-2018-041844**



1 XAVIER BECERRA  
Attorney General of California  
2 STEVEN D. MUNI  
Supervising Deputy Attorney General  
3 JOHN S. GATSCHET  
Deputy Attorney General  
4 State Bar No. 244388  
California Department of Justice  
5 1300 I Street, Suite 125  
P.O. Box 944255  
6 Sacramento, CA 94244-2550  
Telephone: (916) 210-7546  
7 Facsimile: (916) 327-2247

8 *Attorneys for Complainant*

9

10

11

12

13

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

14

In the Matter of the First Amended Accusation  
Against:

Case No. 800-2018-041844

15

**Manjula Bobbala, M.D.**  
100 Prison Road  
Represa, CA 95671

**FIRST AMENDED**

16

**ACCUSATION**

17

Physician's and Surgeon's Certificate  
No. A 87444,

18

19

Respondent.

20

21

**PARTIES**

22

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

23

24

25

2. On or about June 4, 2004, the Board issued Physician's and Surgeon's Certificate Number A 87444 to Manjula Bobbala, M.D. ("Respondent"). The license was in full force and

26

27

28

1 effect at all times relevant to the charges brought herein and will expire on June 30, 2022, unless  
2 renewed.

3 **JURISDICTION**

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

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

11 5. Section 2234 of the Code, states, in pertinent part:

12 The board shall take action against any licensee who is charged with  
13 unprofessional conduct. In addition to other provisions of this article, unprofessional  
conduct includes, but is not limited to, the following:

14 (a) Violating or attempting to violate, directly or indirectly, assisting in or  
15 abetting the violation of, or conspiring to violate any provision of this chapter.

16 ...

17 6. Section 2266 of the Code states, in pertinent part:

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

20  
21 **FACTUAL ALLEGATIONS**

22 **Patient 1<sup>1</sup>**

23 7. On or about June 15, 2017, Patient 1, an inmate at California State Prison-  
24 Sacramento, a California Department of Corrections and Rehabilitation facility (“CSP-Sac”),  
25 presented at the Triage and Treatment Area (“TTA”) at approximately 6:20 p.m. Patient 1  
26 showed evidence of physical assault and trauma in the form of blood and bruising on the left side

27 \_\_\_\_\_  
28 <sup>1</sup> Witness names have been removed to protect confidentiality. All witnesses will be fully  
identified in discovery.

1 of his face. A TTA nurse performed a brief examination and could not determine if there were  
2 any other injuries present. The TTA nurse documented that Patient 1 reported that he had pain to  
3 the right side of his forehead and his back, that Patient 1 was laughing while questioned, that  
4 Patient 1 had slightly slurred speech, and that Patient 1 responded to all questions. The TTA  
5 nurse contacted the on duty physician, Doctor 1, at approximately 6:40 p.m., and provided an  
6 assessment of Patient 1.

7 8. Doctor 1, who was not on site in the TTA, issued orders to have Patient 1 transferred  
8 to a local hospital emergency room to receive care and treatment. The Respondent, the Chief  
9 Medical Executive at CSP-Sac, was informed of the impending transfer, contacted Doctor 1, and  
10 instructed Doctor 1 to first evaluate Patient 1 in person at the TTA prior to Patient 1 being  
11 transferred to a local hospital emergency room. According to Doctor 1, the Respondent cancelled  
12 his transfer order pending his evaluation of Patient 1. At approximately 7:30 p.m., Doctor 1  
13 evaluated Patient 1 in the TTA. Doctor 1 noted that Patient 1 had alcohol on his breath, slurred  
14 speech, cervical neck pain, and a facial droop. At approximately 7:37 p.m., Doctor 1 documented  
15 that he contacted the Respondent and informed her of his findings, that the patient had altered  
16 mental status, and needed c-spine clearance. Doctor 1 requested that Patient 1 be transferred to a  
17 local hospital ER for further evaluation.

18 9. The Respondent overruled Doctor 1's transfer request and ordered that Patient 1 be  
19 evaluated in the TTA for the next four hours. The Respondent issued verbal orders for additional  
20 testing including a complete blood count ("CBC"), comprehensive metabolic panel ("CMP") and  
21 urine toxicology screen. Doctor 1 documented that he "absolutely disagree(d)" with  
22 Respondent's treatment plan. On June 16, 2017, at approximately 12:06 a.m., a nurse  
23 documented that he contacted the Respondent and informed the Respondent of Patient 1's current  
24 clinical presentation. According to the nurse, the Respondent discharged Patient 1 from the TTA  
25 after Patient 1 was determined to be stable and in no apparent distress. On June 16, 2017, at  
26 approximately 7:47 a.m., Patient 1 was seen by a nurse in the cell battery and he appeared to be in  
27 no acute distress. On June 16, 2017, at approximately 11:25 p.m., Patient 1 was seen at his cell  
28

1 and he refused to be seen at TTA for follow-up, stating that he had “no complaint, no pain, and no  
2 problem walking, I’m good.”

3 10. The Respondent failed to provide any documentation related to Patient 1 in his  
4 medical record. The Respondent did not document an assessment and treatment plan for Patient  
5 1. The Respondent did not document why she countermanded Doctor 1’s repeated request to  
6 transfer Patient 1 to a local emergency room. The Respondent did not delegate to a subordinate a  
7 request to document a progress note on her behalf.

8 Patient 2

9 11. On or about September 5, 2017, Patient 2, an inmate at CSP-Sac, presented at TTA  
10 for further evaluation of persistent asymptomatic hyponatremia. Doctor 1 had previously seen  
11 Patient 2 on August 28, 2017, for diabetes, hyperlipidemia, and hypothyroidism. On or about  
12 August 28, 2017, Patient 2 had a low sodium result of 127. On or about September 5, 2017,  
13 Doctor 1 confirmed that Patient 2 denied consuming excessive fluids and currently had no  
14 symptoms. Doctor 1 determined that Patient 2 needed to be transferred to San Joaquin General  
15 Hospital code one for further evaluation of low sodium and issued transfer orders.

16 12. On September 5, 2017, at approximately 11:20 a.m., a nurse documented that  
17 Respondent came to the TTA and examined Patient 2. The nurse documented that the  
18 Respondent cancelled Doctor 1’s transfer order and ordered that Patient 2 be given saline in the  
19 TTA. At approximately 1:41 p.m., a nurse documented that the Respondent was informed of  
20 Patient 2’s status and Respondent had Patient 2 returned to housing. The nurse documented that  
21 Respondent ordered a basic metabolic panel and Patient 2 was informed of the Respondent’s plan  
22 of care. On September 6, 2017, at approximately 9:58 a.m., the lab result indicated that Patient  
23 2’s sodium remained at 127. A nurse documented that they contacted the Respondent and the  
24 Respondent ordered that Patient 2 receive saline. Patient 2 refused to receive saline. At  
25 approximately 1:55 p.m., a nurse documented that the Respondent requested that Patient 2 come  
26 to the clinic for further testing. The nurse documented that Patient 2 refused to see the  
27 Respondent and went back to his cell. Patient 2 also refused to take part in any treatment and  
28 refused to provide an additional blood test. The nurse documented that the Respondent was made

1 aware and the Respondent indicated that a new basic metabolic panel would be reoffered to  
2 Patient 2 on the morning of September 7, 2017.

3 13. On September 7, 2017, at approximately 11:38 a.m., Doctor 1 saw Patient 2 in the  
4 TTA. Doctor 1 documented that he had requested Patient 2 be transferred to San Joaquin General  
5 Hospital on September 5, 2017, but that the Respondent had cancelled his orders. Doctor 1  
6 documented that the Respondent ordered that Patient 2 receive saline and have follow-up labs.  
7 Doctor 1 documented that Patient 2's sodium level in the follow-up labs remained at 127. Doctor  
8 1 also documented that Patient 2 refused treatment on September 6, 2017. Doctor 1 examined  
9 Patient 2 and determined that Patient 2 should be transferred to San Joaquin General Hospital for  
10 further treatment. The Respondent initially cancelled Doctor 1's transfer order but allowed  
11 Patient 2 to be transferred when Patient 2 refused further care in the TTA.

12 14. The Respondent failed to provide any documentation related to Patient 2 in his  
13 medical record on September 5, 2017, September 6, 2017, and September 7, 2017. The  
14 Respondent did not document an assessment and treatment plan for Patient 2. The Respondent  
15 did not document why she countermanded Doctor 1's request to transfer Patient 2 to a San  
16 Joaquin General Hospital. The Respondent did not delegate to a subordinate a request to  
17 document a progress note on her behalf.

18 **FIRST CAUSE FOR DISCIPLINE**

19 **(Inadequate and Inaccurate Records)**

20 15. Respondent's license is subject to disciplinary action under Section 2266 of the Code  
21 in that she kept inaccurate and inadequate medical records during her care and treatment of  
22 Patients 1 and 2. The circumstances are set forth in paragraphs 7 through 14, which are  
23 incorporated by reference as if fully set forth herein.

24 ///

25 ///

26 ///

27 ///

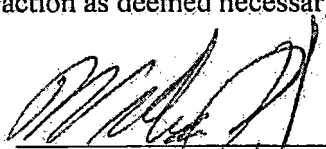
28 ///

PRAYER

1  
2       **WHEREFORE**, Complainant requests that a hearing be held on the matters herein alleged,  
3 and that following the hearing, the Medical Board of California issue a decision:

- 4       1.    Revoking or suspending Physician's and Surgeon's Certificate Number A 87444,  
5 issued to Manjula Bobbala, M.D. ;  
6       2.    Revoking, suspending or denying approval of Manjula Bobbala, M.D.'s authority to  
7 supervise physician assistants and advanced practice nurses;  
8       3.    Ordering Manjula Bobbala, M.D. , if placed on probation, to pay the Board the costs  
9 of probation monitoring; and  
10      4.    Taking such other and further action as deemed necessary and proper.

11  
12    DATED:    SEP 15 2021

  
\_\_\_\_\_  
WILLIAM PRASIFKA  
Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
*Complainant*

13  
14  
15  
16  
17    SA2020303540  
18    35408596.docx  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28