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

In the Matter of the Accusation Against:	)	
LEONARD SUNIL KURIAN, M.D.	)	Case No. 800-2014-008107
Physician's and Surgeon's Certificate No. G 70489	)	
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 June 9, 2017.

IT IS SO ORDERED: May 11, 2017.

MEDICAL BOARD OF CALIFORNIA

Jamie Wright, JD, Chair
Panel A

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General
BENETH A. BROWNE
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California Department of Justice
300 So. Spring Street, Suite 1702
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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: **LEONARD SUNIL KURIAN, M.D.** **1331 West Avenue J, Ste. 102** **Lancaster, CA 93534** **Physician's and Surgeon's Certificate No. G70489,** Respondent.	Case No. 800-2014-008107 OAH No. 2016080204 **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 Beneth A. Browne, Deputy Attorney General.

2. Respondent Leonard Sunil Kurian, M.D. (Respondent) is represented in this proceeding by attorney Dennis R. Thelen, Esq., whose address is: P.O. Box 12092 Bakersfield, CA 93389-2092.

3. On or about December 17, 1990, the Board issued Physician's and Surgeon's

Certificate No. G70489 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2014-008107, and will expire on April 30, 2016, unless renewed.

JURISDICTION

4. Accusation No. 800-2014-008107 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 13, 2016. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2014-008107 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 Accusation No. 800-2014-008107. 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 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.

CULPABILITY

9. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2014-008107.

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.

CIRCUMSTANCES IN MITIGATION

11. Respondent has been compliant with the terms of his current probation. He is admitting responsibility at an early stage in the proceedings.

CONTINGENCY

12. 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.

13. 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.

14. 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

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G70489 issued to Respondent shall be and is hereby subject to one additional year of probation pursuant to California Business and Professions Code section 2227, subdivision (a). The one additional year shall be added to his current seven-year probation being served according to the Decision entered in *In the Matter of the First Amended Accusation Against Leonard Sunil Kurian, M.D.*, Case No. 05-2011-214708, as contained in Exhibit B.

1. PROBATION COMPLIANCE. The Decision in *In the Matter of the First Amended Accusation Against Leonard Sunil Kurian, M.D.*, Case No. 05-2011-214708, as contained in Exhibit B, shall remain in full force and effect, with the addition of one year of probation as ordered herein.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Dennis R. Thelen, Esq. 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: 4/21/17

LEONARD SUNIL KURIAN, M.D.
Respondent

I have read and fully discussed with Respondent LEONARD SUNIL KURIAN, 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: 2-22-17

DENNIS R. THELEN, ESQ.
Attorney for Respondent

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ENDORSEMENT

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

Dated: 2/22/17

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

Beneth A Browne

BENETH A. BROWNE
Deputy Attorney General
Attorneys for Complainant

LA2015602118
62296328

Exhibit A

Accusation No. 800-2014-008107

KAMALA D. HARRIS
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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: LEONARD SUNIL KURIAN, M.D. 1331 West Avenue J, Ste. 102 Lancaster, CA 93534 Physician's and Surgeon's Certificate No. G70489, Respondent.	Case No. 800-2014-008107 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California.

2. On or about December 17, 1990, the Medical Board issued Physician's and Surgeon's Certificate Number G70489 to Leonard Sunil Kurian, 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 April 30, 2016, unless renewed.

JURISDICTION

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

4. Section 2229 of the Code states, in subdivision (a):

"Protection of the public shall be the highest priority for the Division of Medical Quality,[1] the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority."

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

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.

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[1] Pursuant to Business and Professions Code section 2002, the "Division of Medical Quality" or "Division" shall be deemed to refer to the Medical Board of California.

"(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 which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated 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."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent Leonard Sunil Kurian, M.D. is subject to disciplinary action under section 2234, subdivision (b), in that he was grossly negligent in the care and treatment of a patient. The circumstances are as follows:

9. On or about September 9, 2010, Patient J.V.[2] had an appointment at Respondent's office. She complained of heavy, irregular, painful menstrual periods of eight to ten days. An ultrasound exam from the prior day showed large multiple uterine fibroids. The largest one was on the posterior right side measuring 5.8 cm. Another posterior fibroid measured 3.6 cm and an anterior lower uterine segment fibroid measured 3 cm. Medical history was noted to include thyroid dysfunction and anemia. Her obstetric history was noted to include: 4 gravida (total past pregnancies); 2 full term pregnancies; 1 spontaneous abortion; 1 ectopic pregnancy, 2 para (pregnancies producing one or more viable offspring), no c-sections and no hysterectomy. She

[2] Patients are referred to by initials in this accusation to protect their privacy.

was not pregnant. Prior surgeries were noted to include breast biopsy of the right breast with a lumpectomy being benign, tubal ligation, tubal reanastomosis and an ectopic pregnancy in the right tube. Notes indicated that J.V. stated she was tired of the heavy painful periods and would like to have a myomectomy since she wanted to preserve her fertility. Respondent noted discussing a robot assisted uterine myomectomy. Respondent's notes failed to include: a detailed medical history; surgical methodology that had been used for the tubal ligation or ectopic pregnancy; description of a physical examination of J.V.'s abdomen including the location of any scars from J.V.'s previous surgeries; quantitation of J.V.'s uterine size; or description of palpable fibroids.

10. On or about November 11, 2010, Respondent conducted a preoperative consultation with J.V. Respondent documented obtaining informed consent from J.V. for a robotically assisted (laparoscopic) uterine myomectomy to preserve J.V.'s fertility and chromopertubation.[3] J.V. signed consent forms that she understood and accepted the risks of robot assisted uterine myomectomy and chromopertubation. J.V. was not advised and did not therefore provide informed consent with regard to the risk of a prolonged surgery due to Respondent's having only performed one or two of the same procedures using the same method before and having received training for the procedure only about six months previously.

11. There is no documentation that J.V. was provided information about alternative therapies. An open laparotomy would have taken approximately 90 minutes to 2 hours. Alternative therapies should have included laparotomy, uterine arterial embolization or Lupron therapy without surgery, bilateral salpingectomies, endometrial ablation and even hysterectomy. There is also no documentation that Respondent discussed whether J.V. should receive a thorough fertility evaluation.

12. There is no documentation of a physical exam except the patient's pulse, weight and blood pressure. Respondent's notes again failed to include: a detailed medical history; surgical methodology that had been used for the tubal ligation or ectopic pregnancy; description of a

[3] Chromopertubation involves instilling dye through the fallopian tubes to assess tubal patency, relevant to assessing J.V.'s fertility.

physical examination of J.V.'s abdomen including the location of any scars from J.V.'s previous surgeries; quantitation of J.V.'s uterine size; or description of palpable fibroids. Additionally, Respondent failed to describe a plan to remove the fibroids from the abdomen, rather than using the morcellator to grind up and extract the tissue, a technique that increases risks of injury to bowel or other organs and risks seeding the abdominal cavity with myomatous tissue cells which have been proven to grow where they land.

13. On November 20, 2010, Respondent issued pre-operative orders. They indicated that the surgical procedure would include robotic assisted uterine myomectomy and chromopertubation. Respondent's notes lacked the same documentation that was lacking in previous appointments referenced above.[4]

14. On November 22, 2010, the patient was admitted for the surgery. Respondent performed a history and physical examination of J.V. at the hospital. Again, Respondent's notes lacked the same documentation that was lacking in previous appointments on September 9, November 11 and November 20, 2010, referenced above. Patient J.V. signed additional consent forms that she understood and accepted the risks of robot assisted uterine myomectomy and chromopertubation.

15. The surgery lasted approximately seven hours. Although chromotubation had been listed as a procedure on all consents, the operative report lacks any reference to it. Additionally, although the surgery was performed to "preserve fertility," the operative report does not mention or report pelvic adhesions, the condition of J.V.'s fallopian tubes, or the integrity of her endometrial cavity after the myomectomies. The operative report does not document an instrument count. The operative report does, erroneously, state that the Rumi catheter was removed prior to beginning the laparoscopy.

16. On or about November 24, 2010, post op day two, J.V. reported her pain level to be

[4] In previous appointments on September 9 and 11, 2010, Respondent's notes failed to include: a detailed medical history; surgical methodology that had been used for the tubal ligation or ectopic pregnancy; description of a physical examination of J.V.'s abdomen including the location of any scars from J.V.'s previous surgeries; quantitation of J.V.'s uterine size; a description of palpable fibroids; or any appropriate plan to remove the fibroids from the abdomen.

increasing during the morning. She requested pain medication. A nurse reported she had an elevated temperature of 100.1°F. Patient J.V. was not evaluated by exam or laboratory studies and the etiology of her increased pain and temperature elevation were not determined. Tylenol was administered to J.V. per Respondent who discharged J.V. over the phone. J.V. was not seen on the day of discharge with appropriate notes.

17. On or about December 14, 2010, J.V. was seen by Respondent for a brief office visit. She expressed no complaints. She was shown intraoperative photos. No pelvic examination was performed. J.V.'s age was noted to be 40 years old when in fact she was 36 years old.

18. On or about January 10, 2011, J.V. was seen at Respondent's office. She presented with vaginal odor of two weeks duration. A hospitalist covering Respondent's office performed a pelvic examination and found a foreign object in J.V.'s vagina. A cervical cup device was removed. A complete blood count was ordered. Doxycycline,[5] Flagyl (metronidazole)[6] and clindamycin[7] were given to J.V. and she was advised to return in 24 hours.

19. On or about January 11, 2011, J.V. had a follow up visit, and reported feeling better but stating that she was very ill the prior night with fever, nausea and vomiting after taking her second dose of antibiotics. The hospitalist covering Respondent's office advised her that she could discontinue clindamycin but emphasized the importance of completing Flagyl and doxycycline therapy. J.V. was informed that her complete blood count results were normal. She was advised to return in two days to evaluate symptomology and review cultures. She provided a urine sample for analysis. Subsequently, J.V. did not return to Respondent's office.

20. On or about January 13, 2011, J.V.'s urine culture was reported to be positive for Escherichia coli (E. coli) which was sensitive to tetracycline. There is no documentation as to

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[5] Doxycycline is an antibiotic that is used in the treatment of several types of infections caused by bacteria and protozoa.

[6] Metronidazole is also an antibiotic and antiprotozoal medication. It is marketed under the brand name Flagyl among others.

[7] Clindamycin is an antibiotic used to treat certain serious bacterial infections. It is marketed under the brand name Cleocin.

whether there was follow-up regarding the positive results. Notes show that Bactrim[8] was prescribed although the patient was on doxycycline, but there is no documentation of whether J.V. was even informed of the results or provided the prescription or medication.

21. Respondent was grossly negligent in his care and treatment of Patient J.V., taken individually or collectively, when he failed to obtain her informed consent prior to performing surgery on her as follows:

(a) Respondent failed to adequately educate Patient J.V. or document educating her that due to his inexperience and the high learning curve of laparoscopic surgery, there was a risk that the surgery would be prolonged.

(b) Respondent failed to advise Patient J.V. of the risk to her intra-abdominal organs because of scarring and adhesions from previous surgeries.

(c) Respondent failed to advise Patient J.V. about numerous possible alternative surgical and nonsurgical therapies available so that she could fully assess risk and weigh her options.

22. Respondent was grossly negligent in his care and treatment of Patient J.V., taken singularly or collectively, when he repeatedly failed to document necessary information in Patient J.V.'s medical records, as follows:

(a) Respondent failed, in office notes, to include a detailed medical history or evidence of a physical exam.

(b) Respondent failed, in office notes, to document the surgical methodology that had been used for treating J.V.'s prior ectopic or tubal reversal.

(c) Respondent failed, in documenting the physical examination of JV's abdomen, to describe the location of the scars from JV's previous surgeries.

(d) Respondent failed, in office notes, to describe palpable fibroids or quantitate uterine size.

(e) Respondent failed, in the informed consent, to fully explain the robotic

[8] Bactrim is the brand name of a product that contains sulfamethoxazole and trimethoprim, antibiotics that treat different types of infection caused by bacteria.

procedure beyond simply stating that the robot facilitates minimally invasive surgery.

(f) Respondent failed, in pre-operative notes and the operative report, to document an appropriate plan to remove the fibroids from J.V.'s abdomen.

(g) Respondent failed, in the operative report or any post-operative notes, to mention chromopertubation or to document its results although it was listed as a procedure on all consents.

(h) Respondent failed, in the operative report, to document pelvic adhesions, the condition of the fallopian tubes or the integrity of the endometrial cavity after the myomectomy although the procedure was performed to preserve J.V.'s fertility.

(i) Respondent failed, in the operative report, to document an instrument count.

(j) Respondent erroneously documented in the operative report that the Rumi catheter was removed prior to beginning the laparoscopy.

(k) Respondent failed, in the operative report, to document the removal of instrumentation from the vagina.

(l) Respondent failed, post-operatively on the day of discharge, to see J.V. and prepare appropriate notes regarding her status.

(m) Respondent failed, in office notes after J.V.'s surgery, to document notifying J.V. of any results of lab work performed in his office or appropriately following up on positive results.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

23. Respondent Leonard Sunil Kurian, M.D. is subject to disciplinary action under section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of a patient. The circumstances are as follows:

24. The facts and circumstances as alleged in paragraphs 9 through 20 are incorporated here as if fully set forth.

25. Respondent was negligent in his care and treatment of Patient J.V., taken individually or collectively, when he failed to obtain her informed consent prior to performing surgery on her

as follows:

(a) Respondent failed to adequately educate Patient J.V. or document educating her that due to his inexperience and the high learning curve of laparoscopic surgery, there was a risk that the surgery would be prolonged.

(b) Respondent failed to advise Patient J.V. of the risk to her intra-abdominal organs because of scarring and adhesions from previous surgeries.

(c) Respondent failed to advise Patient J.V. about numerous possible alternative surgical and nonsurgical therapies available so that she could fully assess risk and weigh her options.

26. Respondent was negligent in his care and treatment of Patient J.V., taken singularly or collectively, when he repeatedly failed to document necessary information in Patient J.V.'s medical records, as follows:

(a) Respondent failed, in office notes, to include a detailed medical history or evidence of a physical exam.

(b) Respondent failed, in office notes, to document the surgical methodology that had been used for treating J.V.'s prior ectopic or tubal reversal.

(c) Respondent failed, in documenting the physical examination of JV's abdomen, to describe the location of the scars from JV's previous surgeries.

(d) Respondent failed, in office notes, to describe palpable fibroids or quantitate uterine size.

(e) Respondent failed, in the informed consent, to fully explain the robotic procedure beyond simply stating that the robot facilitates minimally invasive surgery.

(f) Respondent failed, in pre-operative notes and the operative report, to document an appropriate plan to remove the fibroids from J.V.'s abdomen.

(g) Respondent failed, in the operative report or any post-operative notes, to mention chromopertubation or to document its results although it was listed as a procedure on all consents.

(h) Respondent failed, in the operative report, to document pelvic adhesions,

the condition of the fallopian tubes or the integrity of the endometrial cavity after the myomectomy although the procedure was performed to preserve J.V.'s fertility.

(i) Respondent failed, in the operative report, to document an instrument count.

(j) Respondent erroneously documented in the operative report that the Rumi catheter was removed prior to beginning the laparoscopy.

(k) Respondent failed, in the operative report, to document the removal of instrumentation from the vagina.

(l) Respondent failed, post-operatively on the day of discharge, to see J.V. and prepare appropriate notes regarding her status.

(m) Respondent failed, in office notes after J.V.'s surgery, to document notifying J.V. of any results of lab work performed in his office or appropriately following up on positive results.

27. Postoperatively, Respondent left a foreign object inside of the patient, specifically, a Rumi catheter cup in the patient's vagina.

28. Respondent prematurely discharged the patient from the hospital, failing to evaluate her and evaluate the etiology and for possible infection given that she experienced pain and a fever over 100 degrees.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Accurate and Adequate Medical Records)

29. Respondent Leonard Sunil Kurian, M.D. is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records relating to the provision of services to Patient J.V., thereby committing unprofessional conduct. The circumstances are as follows:

30. Paragraphs 9 through 20 are incorporated herein as if fully set forth.

DISCIPLINARY CONSIDERATIONS

31. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about March 2, 2006, in a prior disciplinary action entitled *In the Matter of the Accusation Against Leonard Sunil Kurian, M.D.* before the Medical Board of

California, in Case Number 05-2003-145058, Respondent was issued a Public Reprimand and was required to successfully complete a clinical training program, record keeping course and ethics course based on allegations of unprofessional conduct in the care and treatment of a patient. That decision is now final and is incorporated by reference as if fully set forth herein.

32. To further determine the degree of discipline, if any, to be imposed on Respondent Leonard Sunil Kurian, M.D., Complainant alleges that on or about May 8, 2015, in a prior disciplinary action entitled *In the Matter of the First Amended Accusation Against Leonard Sunil Kurian, M.D.* before the Medical Board of California, in Case Number 05-2011-214708, Respondent's license was revoked, the revocation was stayed, and he was placed on probation for seven years and was required, again, to successfully complete a clinical training program, record keeping course and ethics course. Additionally, after successfully completing a clinical training program, Respondent's probation requires that he participate in a Professional Enhancement Program including quarterly review of Respondent's charts; semi-annual assessment of Respondent's practice; and semi-annual review of Respondent's professional growth and education. The discipline was based on allegations of unprofessional conduct relating to his care and treatment of a patient in 2007 who died, a patient in 2010 and a patient in 2011 who died. That decision is now final and is incorporated by reference as if fully set forth 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 G 70489, issued to Leonard Sunil Kurian, M.D.;

2. Revoking, suspending or denying approval of Leonard Sunil Kurian, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Leonard Sunil Kurian, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: April 13, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
State of California
Complainant

LA2015602118
61919701

Exhibit B

Decision - Case No. 05-2011-214708

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

In the Matter of the First Amended Accusation Against:	)	
Leonard Sunil Kurian, M.D.	)	Case No. 05-2011-214708
Physician's and Surgeon's Certificate No. G 70489	)	
Respondent	)	

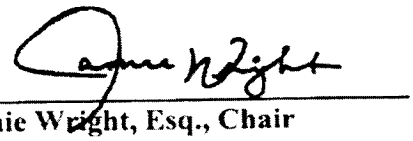
DECISION

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 May 8, 2015.

IT IS SO ORDERED: April 9, 2015.

MEDICAL BOARD OF CALIFORNIA



Jamie Wright, Esq., Chair
Panel A

KAMALA D. HARRIS
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E. A. JONES III
Supervising 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: LEONARD SUNIL KURIAN, M.D. 1331 West Avenue J, Ste. 102 Lancaster, CA 93534 Physician's and Surgeon's Certificate No. G 70489 Respondent.	Case No. 05-2011-214708 OAH No. 2013110784 **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. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Beneth A. Browne, Deputy Attorney General.

2. LEONARD SUNIL KURIAN, M.D. ("Respondent") is represented in this proceeding by attorney Henry Lewin, Esq., whose address is: 11377 West Olympic Blvd., 5th Floor, Los Angeles, CA 90064-1683.

3. On or about December 17, 1990, the Medical Board of California issued Physician's and Surgeon's Certificate No. G 70489 to 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. 05-2011-214708 and will expire on April 30, 2016, unless renewed.

JURISDICTION

4. First Amended Accusation No. 05-2011-214708 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on April 8, 2014. Respondent had previously timely filed his Notice of Defense contesting the charges.

5. A copy of First Amended Accusation No. 05-2011-214708 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. 05-2011-214708. 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 be represented by counsel at his own expense; 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.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in First Amended

Accusation No. 05-2011-214708, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent admits to the truth of the Third Cause for Discipline in the First Amended Accusation. For the purpose of resolving the First Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis as to other allegations in the First Amended 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.

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

CONTINGENCY

12. 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.

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

14. 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

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 70489 issued to Respondent LEONARD SUNIL KURIAN, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for seven (7) years on the following terms and conditions.

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, 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 40 hours per year, for each year of probation. 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 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. MEDICAL RECORD KEEPING COURSE. Within 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 (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 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 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the 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 program would have been approved by the Board or its designee had the program 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 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. CLINICAL TRAINING PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program"). Respondent shall successfully complete

the Program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), First Amended Accusation, and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. Determination as to whether Respondent successfully completed the examination or successfully completed the program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical training program 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. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program have been completed. If the Respondent did not successfully complete the clinical training program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

Within 30 days after Respondent has successfully completed the clinical training program, Respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the entire term of probation, or until the Board or its designee determines that further participation is no longer necessary.

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

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

6. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

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

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

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

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9. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

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

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

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

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

12. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

13. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation,

or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

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

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

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Henry Lewin, Esq. 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: 1/2/15

LEONARD SUNIL KURIAN, M.D.
Respondent

I have read and fully discussed with Respondent LEONARD SUNIL KURIAN, 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: 01/02/15

HENRY LEWIN, ESQ.
Attorney for Respondent

ENDORSEMENT

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

Dated: 1/2/15

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

BENETH A. BROWNE
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 05-2011-214708

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

In the Matter of the First Amended Accusation Against: LEONARD SUNIL KURIAN, M.D. 1331 West Avenue J, Suite 102 Lancaster, California 93534 Physician's and Surgeon's Certificate No. G 70489 Respondent.	Case No. 05-2011-214708 **FIRST AMENDED ACCUSATION**

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.

2. On or about December 17, 1990, the Medical Board of California issued Physician's and Surgeon's Certificate Number G 70489 to Leonard Sunil Kurian, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges herein and will expire April 30, 2014, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section

references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2229 of the Code states, in subdivision (a):

"Protection of the public shall be the highest priority for the Division of Medical Quality,[1] the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority."

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

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.

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[1] Pursuant to Business and Professions Code section 2002, the "Division of Medical Quality" or "Division" shall be deemed to refer to the Medical Board of California.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview scheduled by the mutual agreement of the certificate holder and 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."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent is subject to disciplinary action under section 2234, subdivision (b), in that he was grossly negligent in the care and treatment of three patients. The circumstances are as follows:

Patient C.S.

9. On or around April 18, 2007, C.S., a 28-year-old married female, presented to Respondent, a gynecologist and obstetrician in Lancaster, for her first prenatal visit. C.S. was Gravida 2, Para 0; she had had two pregnancies but no live births. C.S.'s last menstrual period was on February 28, 2007, her menses were irregular, and she had a history of infertility. C.S.'s past medical history was subsequently noted as negative.

10. Respondent had previously treated C.S. Respondent had documented a diagnosis of polycystic ovary syndrome (PCOS) in C.S. in 2000, presenting as androgen excess, hirsuitism,

anovulation, weight gain and infertility. Respondent treated C.S. with Metformin and recommended fertility treatment with Clomid when she was ready to conceive. On November 30, 2006, Respondent had referred C.S. to a reproductive endocrinologist (REI). Lab work on C.S. dated January 31, 2007, reflected elevated testosterone and DHEAS,[2] low progesterone, and C.S. being heterozygous for the MTHFR[3] mutation. Anti-phospholipid antibody results were not obtained because, Respondent has testified, she had no risk factors for thrombosis.

11. On or about April 26, 2007, C.S. presented at the Antelope Valley Hospital Emergency Room complaining of pelvic pain. The emergency room records document C.S.'s medications as including 40 mg CQ Lovenox, baby ASA, Folic Acid, and Progesterone. An intrauterine pregnancy showing 2 gestational sacs with fetal poles was identified. A past history of coagulopathy resulting in a "hypercoaguable" state was listed. The physical exam was negative. An ultrasound confirmed a twin gestation at 7 weeks 4 days with fluid in the gestational sacs. The final diagnosis was threatened abortion with a ruptured ovarian cyst.

12. On or about April 30, 2007, C.S. was referred to a perinatology (a maternal and fetal medicine (MFM) specialist).

13. On May 22, 2007, C.S. received an ultrasound with the perinatologist. It revealed "no obvious problems in either fetus." The plan was to await biochemistry results. He documented that although it was an in vitro fertilization pregnancy (IVF), C.S. had no history of pregnancy losses or DVT. However, he noted, there was a family history of coagulopathies. The perinatologist recommended continuing Aspirin alone without Metformin or Lovenox, but noted that complete blood work was not available for review. He noted that C.S. was at increased risk for gestational diabetes, given her history of PCOS, twins and maternal obesity.

14. On or about May 22, 2007, C.S. also received genetic counseling where risk factors

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[2] DHEAS stands for Dehydroepiandrosterone Sulfate, a hormone that comes from the adrenal gland.

[3] MTHFR is official symbol for the gene "methylenetetrahydrofolate reductase (NAD(P)H)." This gene provides instructions for making an enzyme called methylenetetrahydrofolate reductase. This enzyme plays a role in processing amino acids, the building blocks of proteins. Variations in this gene may be related to occlusive vascular disease, neural tube defects, dementia, colon cancer, and acute leukemia."

were reviewed. C.S. reported that her sister had Lupus, Anti-phospholipid syndrome, positive Anti-cardiolipins, a history of fetal demise, MTHFR mutation, and a child with Autism. On that basis, the perinatologist recommended that C.S. undergo further testing. The risks of Progesterone, Lovenox, and ASA administration during pregnancy were reviewed.

15. Respondent's ACOG antepartum records[4] dated May 31, 2007,[5] for CS indicated she was a G2 PO (had two pregnancies but no live births). CS's last menstrual period was on February 28, 2007, her menses were irregular, and she had a history of infertility. CS's past medical history was entered as negative. CS was allergic to Sulfa.

16. C.S.'s family history was noted as positive for breast cancer and heart disease. Respondent made no reference in the ACOG records, or any other medical records, of C.S.'s family history of coagulapathy. Genetic screening was checked off as all negative – including no blood disorders, no recurrent pregnancy loss, no current medications and no over-the-counter drugs or supplements. Respondent made no reference in the ACOG records, or any other medical records, of C.S.'s current medications, progesterone, Aspirin (ASA) or Lovenox and he did not evaluate their use. Respondent made no reference to C.S.'s fertility problems, or that she had achieved the current pregnancy through in vitro fertilization (IVF), in the ACOG records, or any other medical records, of C.S.. Likewise, Respondent made no reference in the ACOG records, or any other medical records, of C.S., to any consultation with the Reproductive Endrocinologist seen by C.S. The circumstances of the IVF were not considered.

17. On or about May 31, 2007, C.S.'s physical examination was remarkable for a 14-16 week size uterus and "narrow pelvis." Two cold sores were noted. C.S. was given an EDC, expected date of delivery, of December 5, 2007.

18. On or around June of 2007, at 16 weeks gestation, as indicated by Respondent's medical records for C.S., she called Respondent's office and was anxious in light of her sister's

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[4] ACOG stands for The American College of Obstetricians and Gynecologists; ACOG has standard forms many practitioners use.

[5] The Initial Physical Exam documented in the ACOG antepartum records is dated May 31, 2007. Some other items in the ACOG antepartum records were presumably entered subsequently as they occurred.

history of incompetent cervix resulting in a miscarriage at 25 weeks.

19. On or about August 2, 2007, a follow-up ultrasound was performed for the perinatologist. It revealed a normal twin pregnancy at 22 weeks. C.S.'s cervical length was normal. C.S. was advised to reduce activity by 50%.

20. On or about August 13, 2007, C.S. was admitted to Antelope Valley Hospital in premature labor. Her cervical length was shortened with funneling. C.S. was treated with magnesium sulfate and bed rest. Labor was successfully stopped. C.S. remained in the hospital on bed rest. Respondent treated C.S. during her hospital stay.

21. On or about August 21, 2007, sequential suppression boots (thromboguards) were ordered for C.S.

22. On or about September 25, 2007, C.S. was discharged from the Antelope Valley Hospital to Matria Home Health Care on Procardia. Upon discharge, an ultrasound identified a 23 week twin gestation with no fluid around twin A. C.S. was documented as having reported leakage over the past few days. After having been discharged, C.S. was readmitted to the Antelope Valley Hospital with preterm premature rupture of membrane (PPROM) and treated with "rescue" steroids, IV antibiotics, and "not aggressive" tocolysis. C.S. complained of sharp pain in her left groin area unrelated to uterine contractions. Respondent's partner was notified. C.S.'s pain resolved in a few hours. C.S. was observed on bedrest for the remainder of her pregnancy under Respondent's care. During her hospital stay, C.S. was noted to have edema and C.S. complained of left inguinal pain.

23. On or about November 9, 2007, at 36 weeks gestation, Respondent performed an elective c-section on C.S. without complications. C.S. gave birth to healthy baby girl and a healthy baby boy. The twin babies did well.

24. On or about November 12, 2007, C.S. was discharged from the hospital. C.S.'s hemoglobin was 8.6, out of range. C.S. was taking Repliva, an iron supplement and Hydrocodone, a narcotic pain-reliever.

25. On or about November 20, 2007, C.S. had a regular follow up appointment with Respondent to review any complaints she had and check her incision, consistent with his custom

and practice. Respondent documented no complaints and noted the incision was healing well. Aside from referencing the incision, no physical exam or discussion with Respondent was described. Family members of C.S. reported that, at the time, C.S. had a slight fever, an irritating cough, was complaining of painful swelling in her legs and ankles and she urinated frequently, two to three times per day. Lactation was difficult, as she produced little milk. She stated she felt cold all of the time. C.S. was concerned she was having post-partum depression.

26. On or about December 4, 2007, C.S. had her final appointment with Respondent. Respondent documented that she complained of depression, weakness and a cough. Respondent documented that C.S.'s lungs were clear to auscultation. Respondent documented prescribing C.S. a cough suppressant, an antidepressant and ordered lab work. Respondent ordered a CBC and thyroid studies. Respondent knew that C.S.'s family planned to move to Idaho and would be driving there soon. Respondent gave C.S. no directives and made no recommendations to C.S. about the driving trip to move to Idaho or any subsequent treatment. Respondent had no concerns about her driving aside from the usual situation when people are driving any distance when they are pregnant or in the post-partum period, notwithstanding the risks for patient C.S. developing thrombosis.

27. On or about December 6, 2007, C.S. and her family began their drive to Idaho. On or about December 7, 2007, at 4:30 p.m., C.S. and her family arrived at the home of relatives in Idaho. C.S. visited with immediate and extended family. Less than two hours later, C.S. lifted a bag, climbed the stairs of her family's home, collapsed and lost consciousness. Relatives called 911 and summoned an ambulance. An ambulance arrived but emergency medical personnel were unable to revive C.S. They drove her to a Boise hospital where she was officially pronounced dead.

28. Respondent was grossly negligent in his care and treatment of patient C.S., taken singularly or collectively, when he:

(1) initiated obstetric care of C.S. without first obtaining a complete: (a) history of her then-current pregnancy; (b) list of her then-current medications; and (c) family history;

(2) failed to recognize patient C.S.'s risk of thrombosis; and

(3) failed to anti-coagulate C.S. in the weeks following her c-section.

Patient H.M.

29. On or about early October, 2010, H.M., a 37-year-old patient, presented to Respondent with a chief complaint of chronic right pelvic pain with an acute exacerbation of the pain more recently. She provided Respondent an ultrasound, the report for which identified a 6 cm complex right ovarian cyst.[6] Due to the chronic pelvic pain associated with her identified right ovarian cyst and her profound fear of cancer, H.M. requested Respondent to perform a right oophorectomy.[7] H.M.'s history included right lower quadrant pain for years, since she was seventeen to eighteen years old. Her history was strictly of right- sided pain. H.M.'s past medical history was significant for a connective tissue disorder,[8] Hashimotos disease,[9] herpes, and interstitial cystitis.[10] She described an extensive surgical history, significant for a hysterectomy,[11] right ovarian cystectomy,[12] and a laparoscopy for adhesiolysis.[13]

30. Respondent performed a pelvic exam and identified tenderness and fullness of the

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[6] An ovarian cyst is a sac filled with fluid that forms on or inside of an ovary.

[7] Oophorectomy is the surgical removal of one or both ovaries.

[8] Connective tissues are groups of fibers and cells that "connect" the framework of the body and literally hold it together. Their functions include cushioning, protecting, supporting, insulating and strengthening the body's tissues and organs. Examples of connective tissue are tendons, ligaments, cartilage, blood, bone, and the dermis of the skin. Because connective tissues exist in so many structures of the body, disorders of these tissues may involve a variety of symptoms, including pain and dysfunction in different areas of the body.

[9] Also called Hashimoto's thyroiditis, Hashimoto's disease is an autoimmune disease, a disorder in which the immune system turns against the body's own tissues.

[10] Interstitial cystitis is a chronic inflammation of the lining of the bladder causing it to scar, stiffen and expand differently, creating chronic pain, discomfort, a sense of urgency and increased frequency of urination.

[11] A hysterectomy is surgery to remove a woman's uterus or womb.

[12] An ovarian cystectomy is surgical removal of an ovarian cyst from an ovary.

[13] Adhesiolysis is the process of cutting adhesions between two abdominal structures - this is done laparoscopically to minimize complications. H.S. had lysis of pelvic adhesions (24, 30).

right adnexa. His physical exam of H.M. pinpointed the pain with manipulation of the right ovary. Ovarian tumor markers were negative, but Respondent agreed that he would perform laparoscopic robotic surgery on H.M. and he assured H.M. that he would remove her right ovary in order to help her chronic pain. Respondent appeared to consider the ultrasound report to provide a definitive diagnosis, but a definitive diagnosis of pelvic pain requires laparoscopy where direct visualization and possibly biopsies will diagnose pathology.

31. Surgery was scheduled for October 25, 2010.[14] Respondent obtained H.M.'s operative consent to perform a laparoscopic right salpingo-oophorectomy.[15] Due to H.M.'s fear of cancer, the consent also documented a possible laparotomy[16] with left oophorectomy and omentectomy[17] and pelvic lymphadenectomy, plus rapid frozen section. Additional procedures beyond the right salpingo-oophorectomy would only be performed, however, if findings during surgery were suspicious for malignancy and a frozen section was performed; only in that case would a laparotomy, along with a complete oncologic dissection, be performed, including removal of H.M.'s left ovary.

32. Respondent failed to provide H.M. informed consent; he failed to impart to her in laymen's terms without ambiguity, what procedure(s) would be performed and under what circumstances and the risks, benefits and alternative treatments available. Respondent's documentation of informed consent failed to clearly explain the possible laparotomy. His documentation was unclear as to whether an oncologist would be consulted or on standby. The documentation also lacked a description of Respondent's discussion of the procedure with H.M.

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[14] In light of her previous pelvic surgeries and the anticipated adhesions - a urologist was consulted for ureteral stents in expectation of a difficult adhesiolysis.

[15] Salpingo-oophorectomy is the removal of the fallopian tube (salpingectomy) and ovary (oophorectomy).

[16] Laparotomy is surgery performed on the abdomen using the traditional full-size incision, rather than a minimally invasive approach. The equivalent procedure using the minimally invasive laparoscopic technique is called laparoscopy.

[17] Omentectomy: Surgery to remove part or all of the omentum, an large apron of fatty tissue containing veins, arteries, lymphatics. The omentum attaches to and nourishes the stomach and the entire colon.

33. On or about October 24, 2010, H.M. received an admission history and physical. It documented that the right adnexa was full and tender. The admission history and physical stated that the chief complaint was severe right pelvic pain. It detailed a complex 6 cm septated right ovary.[18] All pre-operative findings pointed to right adnexa pathology. H.M. had a lengthy history of right sided pelvic pain. She previously underwent a right ovarian cystectomy which commonly causes adhesions to the organ. On exam, her pain localized to the right ovary. An ultrasound defined a complex right ovarian cyst.[19]

34. On or about October 25, 2010, during the laparascopic procedure, Respondent failed to follow-up on the information obtained in the pre-operative work-up of H.M., to evaluate the presumed diagnosis and to remove the pathology identified as the most likely source of the pelvic pain. Although all pre-op findings pointed to right adnexa pathology, the entire operative report failed to mention the right ovary. Intraoperatively, Respondent failed to explore H.M.'s right ovary.

35. Instead, Respondent surgically removed H.M.'s left ovary. The pre-operative diagnosis had been erroneously entered on the operative report. The actual pre-operative diagnosis was complex right ovarian cyst, but the operative report mistakenly indicated a complex left ovarian cyst. The operative report referenced the left ovary as multi-cystic and noted bilateral abdominal adhesions. Respondent later admitted that the cyst appeared benign and, in fact, pathology confirmed a simple cyst hemorrhagic follicle, a corpus albicantia,[20] along with the fallopian tube and adhesions. The benign pathology would not explain the H.M.'s symptoms of severe right pelvic pain.

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[18] A septated ovarian cyst is composed of both solid and liquid matter and has a wall in it (septum means wall).

[19] A complex ovarian cyst is a type of cyst that has both solid and liquid components. Found in the ovary and encased in a thin wall, it can appear to be exactly like a basic cyst, but it has a higher potential to become life threatening and should be treated quickly once detected.

[20] Corpus albicans (corpora albicantia) are white fibrous tissue that replaces the regressing corpus luteum in the human ovary in the latter half of pregnancy, or soon after ovulation when pregnancy does not supervene. The corpus luteum is a progesterone-secreting yellow glandular mass in the ovary formed from the wall of an ovarian follicle that has matured and discharged its ovum.

36. Likewise, bilateral abdominal adhesions[21] were found, but they would not explain H.M.'s symptoms of severe right pelvic pain. No adhesions were found on H.M.'s pelvis. Laparoscopy is performed in order to diagnose and treat pelvic pathology, so during a laparoscopy for pelvic pain, the entire pelvis must be completely evaluated and the findings documented. Here, because H.M.'s chief complaint was chronic right lower quadrant pain, the laparoscopic examination should have concentrated on identifying an explanation for that pain.

37. In the operative report, Respondent incorrectly documented both a preoperative diagnosis and a post-operative diagnosis of complex left ovarian cyst. Respondent failed to document any examination of the right ovary or pelvis to explain the pre-operative findings. Respondent failed to describe his thought process leading him to surgically remove H.M.'s left ovary and not her right ovary. Additionally, Respondent failed to integrate findings from the history and physical exam on H.M. over time to formulate a plausible differential diagnosis and plan of treatment. The surgical procedure that Respondent performed did not conform to the pre-operative findings. Because there were no pelvic adhesions that might cause referred pain, to correlate the findings at surgery with the history and physical, the right ovary should have been thoroughly evaluated and the findings documented.

38. Although the pre-operative ultrasound had reported a 6 cm septated right ovarian cyst with possible hemorrhagic component, photos from the laparoscopy showed a right tube and ovary adherent to the pelvic sidewall. This 'complex' of structures can appear on an ultrasound as reported- a complex cystic right ovary. Respondent demonstrated an inability to integrate basic knowledge of ovarian physiology into the plan of treatment of H.M.

39. When H.M. had undergone a hysterectomy, the procedures included dissection of her broad ligament and mesosalpinx along with transection of the her ovarian ligament. The unavoidable trauma to the tissue in these locations undoubtedly resulted in some degree of adhesion formation. A retained ovary is invariably left fixed in closer proximity to the ovary

[21] Abdominal adhesions are bands of fibrous scar tissue that form on organs in the abdomen, causing the organs to stick to one another or to the wall of the abdomen.

fossa[22] or I.P. ligament.[23] Sometimes the ovary becomes transfixed to the vaginal cuff or sidewall following removal of the uterus.

40. With ovarian cystectomy, the trauma to the ovarian capsule will result in the formation of adhesions. This scar tissue may encapsulate the entire ovary and fix it to adjacent structures in the body's attempt to repair damage. The ovary remains dynamic and continues to cyclically respond to pituitary hormone stimulation with maturation of ovarian follicles. This normal physiologic process cyclically results in the formation of ovarian cysts. Rapid growth of cysts can result in hemorrhage into the ovary or beneath the adhesions. The expansion of follicles creates tension on the adjacent peritoneum, which is extremely sensitive to pain. Therefore, these patients will experience acute, chronic, or cyclic pelvic pain as a result of these adhesions. Although Respondent acknowledged the phenomenon of an ovary becoming adherent to the sidewall after a hysterectomy, he mistakenly described the condition as rarely painful.

41. Post-operatively, H.M. continued to experience right pelvic pain. On November 9, 2010, H.M. presented for a repeat pelvic ultrasound. Consistent with the information Respondent last conveyed to her, she reported that on October 25, 2010, she had undergone a right oophorectomy. She learned, however, that she was missing her left ovary and that her right ovary had not been removed. It was present and contained a 3 c.m. complex right ovarian cyst. Had she been fully informed before the surgery, H.M. would not have agreed to it. H.M. eventually sought the care of another gynecologist who performed the right oophorectomy and consequently, H.M. has subsequently required continued estrogen replacement therapy.

42. On or about October 25, 2010, Respondent was grossly negligent in his care and treatment of patient H.M., taken singularly or collectively, when he:

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[22] An ovarian fossa is a depression in the parietal peritoneum of the pelvis in which the ovary is situated.

[23] The suspensory ligament of the ovary, also infundibulopelvic ligament (commonly abbreviated IP ligament or simply IP), is a fold of peritoneum that extends out from the ovary to the wall of the pelvis. The peritoneum is the serous membrane that forms the lining of the abdominal cavity - it covers most of the intra-abdominal organs. It is composed of a layer of mesothelium supported by a thin layer of connective tissue. The peritoneum both supports the abdominal organs and serves as a conduit for their blood and lymph vessels and nerves.

(1) Failed to provide her informed consent;

(2) Failed to integrate findings from a detailed history and physical exam to formulate a plausible differential diagnosis and plan of treatment;

(3) Failed to thoroughly examine and document examining her right ovary during surgery;

(4) Surgically removed her left ovary and not her right ovary.

Patient C.M.

43. On or about Sunday, August 7, 2011, C.M., who was a 34-year-old OB-GYN patient of Respondent, presented by ambulance to the Antelope Valley Hospital Emergency Room. She complained of sharp constant right lower quadrant pain. C.M. was at 38 weeks gestation.[24] An immediate ultrasound was obtained to rule out placenta abruption. Prophylactic ampicillin was administered IV for her positive GBS status. Another physician, covering for Respondent, delivered a healthy baby girl weighing 7 pounds, one ounce, having an 8/9 APGAR score after a rapid and uneventful labor. During C.M.'s labor and delivery hospital stay, nursing notes described right sided pain, continuing abdominal distention, and changes in vital signs.

44. On or around Monday, August 8, 2011, Respondent re-assumed the care of the C.M. following her uneventful vaginal delivery by another physician. C.M. complained of right flank and back pain. The exam was reported as negative and C.M.'s back pain was attributed to chronic muscle strain. Pathology reported a normal placenta. C.M.'s white blood cell count was 4.1.

45. On or about August 9, 2011, C.M. complained of back pain of 3 days duration that had decreased. She had a temperature of 100.1 degrees, respiration at 118, and a pulse of 120. C.M.'s right-sided abdominal pain, present on admission, persisted but had decreased to a 4/10. Respondent was notified by nursing of a change in C.M.'s vital signs when C.M.'s pulse increased to 124 beats per minute, her respirations were at 118 and her temperature was 100.1 degrees. C.M. required further observation. Evaluation for infection was warranted. Further

[24] C.M. was gravida 3, para 2. She had two older children.

studies, including a complete blood count (CBC) and urinalysis, were indicated.

46. Upon resuming care of C.M. post-partum, Respondent failed to adequately evaluate C.M.'s status. He described being unaware of C.M.'s evaluated temperature, change in vital signs, and continuous right-sided pain. Respondent discharged C.M. home to her newborn. Respondent later admitted that he never read the nurses notes documenting the C.M.'s three-day history of pain and change in vital signs. Doing so would not be part of his custom and practice.

47. Two days later, on or about Thursday, August 11, 2011, at 6:20 a.m., C.M. was brought back to the Antelope Valley Hospital Emergency Room. She complained again of sharp right lower quadrant pain. The Emergency Department evaluated C.M. and identified an "acute abdomen" requiring hospital admission. In addition to her right-sided abdominal pain, C.M. complained of nausea and vomiting and gave a three-day history of diarrhea. Her fever had risen to 102 degrees. An ultrasound was ordered. Initial labs identified a stable hemoglobin, a depressed white blood cell count (WBC), and abnormal electrolytes. Additionally, C.M. was both hypotensive, with a blood pressure at 90/58, and tachycardic,[25] with her heart racing at 148 beats per minute.

48. Respondent assumed care of C.M. via a text message at 8:49 a.m. which stated a patient was admitted via the E.R., "SVD 2 days? with abd pain." Respondent texted, "What do they think is the diagnosis?" and received a response, "Unclear. CT suggested hemoperitoneum,[26] but not obvious. Perhaps endomyometritis,[27] but no fever" and "Normal H/H, VVS," "VSS."[28]

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[25] Tachycardic: relating to rapid heart rate.

[26] Hemoperitoneum (sometimes also hematoperitoneum): the presence of blood in the peritoneal cavity. The blood accumulates in the space between the inner lining of the abdominal wall and the internal abdominal organs. It is generally classified as a surgical emergency; in most cases, urgent laparotomy is needed to identify and control the source of the bleeding.

[27] Endomyometritis: sepsis involving the tissues of the uterus. Sepsis refers to a bacterial infection in the bloodstream or body tissues. This is a very broad term covering the presence of many types of microscopic disease-causing organisms. The presence of sepsis is indicated by blood tests showing particularly high or low white blood cell counts. The causative agent is determined by blood culture. In some cases the doctor may order imaging studies to rule out pneumonia, or to determine whether the sepsis has developed from a ruptured appendix or other leakage from the digestive tract into the abdomen.

[28] Normal vital signs.

49. The CT was actually an ultrasound which demonstrated material in the uterus and diffuse fluid in the abdomen. In fact, the patient was febrile, hypotensive and tachycardic with immunosuppression.[29] She complained of nausea, diarrhea, and abdominal pain for days. Urinalysis showed stable hemoglobin, a low WBC, abnormal electrolytes.

50. Nursing staff called Respondent four times during the day and requested him to come evaluate his patient. Respondent was nonresponsive. Respondent also failed to respond to C.M.'s family members' three documented calls to his office requesting him to evaluate C.M. at the hospital. Instead, Respondent remained in his office during the day. At or about 7 p.m. on August 11, 2011, Respondent saw his patient C.M. A pelvic ultrasound that had been performed demonstrated material in C.M.'s endometrial cavity (clots in her uterus) and a large fluid collection in her abdomen.

51. Ten hours after Respondent assumed care of the patient, he saw the patient. Despite the objective information referenced above, Respondent continued with the endometritis[30] and hemoperitoneum diagnosis. C.M. had a normal, uncomplicated vaginal delivery and had two previous children, making most etiologies of blood in the abdomen slim. Further, C.M.'s normal post-partum hemoglobin level had remained stable. Although C.M. was not bleeding, Respondent would carry the diagnosis of endometritis and hemoperitoneum from C.M.'s second admission to the hospital, through her surgery and finally to her "record of death."

52. The interpretation on the ultrasound report, which Respondent read (without viewing the films), and took as fact, was endometritis and hemoperitoneum. On exam, Respondent found that her abdomen was distended and tender, with rebound. There is no evidence that Respondent made himself aware of C.M.'s depressed WBC[31] or abnormal electrolytes. Coupled with his

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[29] Immunosuppression: an abnormal condition of the immune system characterized by markedly inhibited ability to respond to antigenic stimuli.

[30] Endometritis: inflammation of the lining of the uterus (endometrium).

[31] WBC: White blood cell; or leukocytes, are the cells of the immune system that are involved in defending the body against both infectious disease and foreign materials. There are two major categories of white blood cell disorders: proliferative and leukopenias. In the proliferative disorders there is an increase in the number of white blood cells. This increase is commonly reactive (eg., due to infection) but may also be cancerous. In leukopenias there is a (continued...)

History and Physical, C.M.'s depressed WBC and abnormal electrolytes indicated sepsis. Although she was in the midst of a gynecologic emergency, Respondent failed to ever perform a pelvic exam on C.M.

53. Respondent ordered a CT scan. Results were reported at 9:38 p.m. as hematoma in the endometrial cavity, diffuse intra-peritoneal free fluid, distended bowel and intraperitoneal (inside the abdominal cavity) air bubbles. Respondent received the results by telephone. C.M.'s vital signs remained unstable. Despite demonstrated diffuse free fluid and air bubbles in C.M.'s abdomen, however, Respondent did not consider it a surgical emergency. Respondent failed to seek any surgical consult and instead scheduled to perform a D&C[32] and laparoscopy himself without surgical assistance the next day, a Friday, when he normally performed surgeries.

54. The CT scan identified diffuse fluid in the abdomen plus air bubbles. This indicates a ruptured viscus.[33] There is no evidence that the finding was considered. In that the patient was septic with stable hemoglobins, the differential diagnosis should have explored infectious etiologies including endometritis and appendicitis. C.M.'s hemoglobin at 11 was normal and remained stable. Her white blood-cell count was 3.1 with bands and her bicarb was low. Nurse's notes describe a significantly distended abdomen, firm and tender.

55. Although a perforation of a viscus was identified, Respondent ordered a soft diet for C.M. until she was made NPO (oral foods and fluids were withheld) after midnight in preparation for the surgery. No labwork was ordered to be taken until the next morning.

56. Respondent failed to reinterpret the radiologist's differential diagnosis to conform to

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decrease in the number of white blood cells. Both proliferative disease and leukopenias are quantitative disorders of white blood cells. Qualitative disorders of white blood cells are another category. These are disorders in which the number of white blood cells is normal but the cells do not function normally.

[32] Dilation and curettage (D&C): a brief surgical procedure in which the cervix is dilated and a special instrument is used to scrape the uterine lining. It is done to: (1) Remove tissue in the uterus during or after a miscarriage or abortion or to remove small pieces of placenta after childbirth. This helps prevent infection or heavy bleeding. (2) Diagnose or treat abnormal uterine bleeding. A D&C may help diagnose or treat growths such as fibroids, polyps, or endometriosis, hormonal imbalances, or uterine cancer. A sample of uterine tissue is viewed under a microscope to check for abnormal cells.

[33] Viscus: an internal organ

known objective findings of C.M. Instead, Respondent simply took the differential diagnosis provided by radiology as fact; he continued with a diagnosis of endometritis and hemoperitoneum. Respondent failed to evaluate C.M.'s stable hemoglobin of 11 and evidence of sepsis. Respondent never formed a pelvic examination. Respondent never proposed a plausible differential diagnosis.

57. Following an uncomplicated vaginal delivery without prolonged rupture of membranes, endometritis is characterized by pelvic pain accompanied by foul vaginal discharge and/or heavy bleeding. Work-up requires a pelvic exam. Endometrial sampling is for cytology and cultures, for proper diagnosis and treatment. Removal of retained secundines[34] is often the only treatment required. In this case diagnosis of endometritis was made in the absence of classic symptomatology. It was never evaluated via pelvic exam or cervical cultures. A D&C was scheduled to be after a 24 hour delay. Pathology was negative for an infectious process or retained tissue.

58. The next day, on August 12, 2011, at 10:00 a.m., patient C.M. was taken for the scheduled D&C and laparoscopy. Aware that C.M.'s belly was filled with fluid, Respondent had nonetheless opted to do a laparoscopy without any surgical consultation, and without a surgeon readily available. A general surgeon should be present or available during any surgical intervention involving an acute abdomen with sepsis and/or a perforated viscus. Respondent had placed the differential diagnosis provided by radiology as the diagnosis on the surgical note, notwithstanding other objective data not supporting that conclusion. Respondent failed to obtain informed consent for an open procedure.

59. Although the pathology had been negative, Respondent performed a D&C to obtain products of conception. Respondent tried to perform a diagnostic laparoscopy, but it was precluded by adhesions and purulent fluid. Respondent finally sought surgical consultation. The unplanned consultation resulted in a one hour intra-operative delay; when a surgeon was called to the O.R., one was not available for an hour. As a result, C.M. remained under anesthesia for four

[34] Secundines: afterbirth; the placenta and fetal membranes expelled from the uterus after childbirth.

hours total.

60. A general surgeon arrived, confirmed that C.M.'s appendix had burst and completed an appendectomy. Subsequently, Respondent failed to perform a post-operative evaluation of C.M. and failed to have her sent to an acute care unit. Instead, following the laparotomy for a ruptured appendix with diffuse purulent fluid, Respondent wrote a post-operative order sending her to medical surgical nursing unit where C.M. would receive routine post-op care. Critical care consultations for this septic patient with hemodynamic instability who had just undergone four hours of anesthesia and surgery, were only requested several hours later. C.M.'s monitoring results were not checked. An on-call physician assumed care of C.M. at 5:00 p.m. without receiving any communication from Respondent. The on-call physician, covering for Respondent, transferred C.M. to the intensive care unit at about 10:15 p.m. that night and wrote a chart note to Respondent recommending that C.M.'s incision be reopened in light of the known infectious process.

61. The following day, on or about August 13, 2011, because of acute renal failure, a renal specialist was consulted. A pulmonologist consultation was sought. An infectious disease consult was elicited and further antibiotic recommendations were given at 7:20 a.m. At the same time, C.M. went into cardiopulmonary arrest and was pronounced dead at 8:00 a.m.

62. On or about August 7 through August 13, 2011, Respondent was grossly negligent in his care and treatment of patient C.M., taken singularly or collectively, when he:

(1) failed to recognize C.M.'s acute abdomen and waited twelve hours to intervene;

(2) failed to obtain a surgical consult upon admission; and

(3) failed to have a general surgeon available at surgery;

(4) failed to properly integrate objective data when formulating a plan of treatment for C.M.;

(5) failed to provide a prompt evaluation, diagnostic studies, interventions and follow-up of C.M.;

(6) maintained an unsubstantiated differential diagnosis in spite of contradictory evidence and the patient's clinical course; and

(7) failed to adequately evaluate this patient, taken singularly or collectively, on four occasions, including: (a) Prior to discharge post-partum; (b) promptly upon her readmission; (c) prior to formulating a treatment plan; and (d) following a lengthy major surgery.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

63. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he was repeatedly negligent in the care and treatment of four patients. The circumstances are as follows:

Patient C.S.

64. The facts and circumstances as alleged in paragraphs 9 through 27 are incorporated here as if fully set forth.

65. Respondent was repeatedly negligent in his care and treatment of C.S. when he:

(1) initiated obstetric care of C.S. without first obtaining, taken singularly or collectively, a complete: (a) history of her then-current pregnancy; (b) list of her then-current medications; and (c) family history;

(2) failed to recognize the risk of thrombosis in patient C.S.;

(3) failed to anti-coagulate C.S. for weeks following a c-section;

(4) taken singularly and collectively, failed to document: (a) the circumstances of the C.S.'s IVF; (b) the medications prescribed; (c) the initial ultrasound exams; (d) the IVF as it affected the calculation of the EDC; (e) medications taken or complications before and during C.S.'s pregnancy; (f) antepartum treatment plans; (g) perinatology consults; (h) evidence of considering recommendations of consultants; and (i) C.S.'s family history of coagulopathy;

(5) taken singularly and collectively, failed to make proper use of C.S.'s reproductive endocrinologist and perinatologist, by failing to: (a) communicate with them; (b) note their findings; and (c) duly consider their recommendations.

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Patient H.M.

66. The facts and circumstances alleged in paragraphs 29 through 41 are incorporated here as if fully set forth.

67. On or about October 25, 2010, Respondent was repeatedly negligent in his care and treatment of patient H.M. when he:

(1) Failed to provide her informed consent;

(2) Failed to integrate findings from a detailed history and physical exam to formulate a plausible differential diagnosis and plan of treatment.

(3) Failed to thoroughly examine and document examining her right ovary during surgery;

(4) Surgically removed her left ovary and not her right ovary;

(5) Used a pelvic ultrasound for evaluation of her pelvic pain;

(6) Lacked ability to and thereby failed to integrate basic knowledge of ovarian physiology into the plan of treatment of H.M.;

(7) Failed to completely and accurately document subjective and objective findings, assessment of the patient's condition and treatment plan.

Patient C.M.

68. The facts and circumstances alleged in paragraphs 43 to 61 are incorporated here as if fully set forth.

69. On or about August 8 through August 13, 2011, Respondent was repeatedly negligent in his care and treatment of patient C.M. when he:

(1) failed to recognize C.M.'s acute abdomen and waited twelve hours to intervene;

(2) failed to obtain a surgical consult upon admission; and

(3) failed to have a general surgeon available at surgery;

(4) failed to properly integrate objective data when formulating a plan of treatment for C.M.;

(5) failed to provide a prompt evaluation, diagnostic studies, interventions and follow-up of C.M.;

(6) maintained an unsubstantiated differential diagnosis in spite of contradictory evidence and the patient's clinical course; and

(7) failed to adequately evaluate this patient, taken singularly or collectively, on four occasions, including: (a) Prior to discharge post-partum; (b) promptly upon her readmission; (c) prior to formulating a treatment plan; and (d) following a lengthy major surgery.

(8) failed to respond to multiple telephone requests to come to see his patient, who had required emergent admission to the hospital;

(9) discharged C.M. from the hospital on August 9, 2011, without ensuring that she was stable, resolving her complaints, ensuring her vital signs were stable and ensuring that her prognostic indicators were improving; and

(9) failed to properly diagnose and treat the presumed endometritis of C.M.

Patient K.Q.

70. On or about September 10, 2008, patient K.Q. presented to Respondent for an annual examination. She reported heavy menstrual periods and surgical options were reviewed. Hemoglobin was tested at 13.5. At an appointment on or about September 23, 2008, patient K.Q. saw Respondent and complained of heavy irregular menses, with clotting, and cramping. Oral contraceptives had not helped and her husband had had a vasectomy. She also complained that her labia was too large and caused her discomfort. On exam the labia minora were noted to be "elongated (and) hypertrophied." She was given the surgical options of hysteroscopy, and/or, endometrial ablation, along with labiaplasty. She chose endometrial ablation and labiaplasty.

71. On or about October 9, 2008, an ultrasound was reported as normal, except for thickening of the endometrium. An endometrial biopsy was performed in the office demonstrating benign pathology.

72. On or about October 24, 2008, at the Antelope Valley Surgery Center, Respondent performed a diagnostic hysteroscopy, endometrial ablation with novasure and a vaginal labiaplasty on patient K.Q.

73. Respondent could not adequately detail or demonstrate a thorough knowledge of the

labiaplasty procedure. He was not familiar with multiple proven techniques. Likewise, he was not familiar with possible complications with labiaplasty, including common complications with the procedure.

74. Respondent performed novasure endometrial ablation and labiaplasty together and without prophylactic antibiotics despite the risk of contamination, creating a risk of infection at the labiaplasty suture line. A labiaplasty suture line must be kept clean and dry. However, an endometrial ablation involves cauterizing the lining of the uterus creating an open wound that drains for four to eight weeks post-op requiring the patient to wear an absorbant perineal pad continuously. The drainage from an endometrial ablation would result in a continuous flow of bacteria from the vagina to the suture line, the use of perineal pads would cause the area to remain moist, allowing bacteria from the rectum to seed the area, and it would serve as a constant irritant to the wound. Prophylactic antibiotics would be indicated.

75. The operative report regarding the labiaplasty states:

"The labia was extended and marked with a marking pen bilaterally and the excess labial tissue was transected with Metzenbaum scissors. The labia on each side were reapproximated in two layers – the deep layer with 3-0 Vicryl suture in a running stitch and the superficial layer with 4-0 Monocryl suture in a subcuticular stitch. Good hemostasis at the end of the case." The documentation is inadequate. It fails to include details of surgical techniques employed, the type of incision, and the location and placement of incisions and sutures.

76. Prior to surgery, regarding the labiaplasty, Respondent failed to document that he completely described all surgical procedures to be performed, the more commonly encountered complications and alternative treatments available. The written consent was limited to describing endometrial ablation and a potential blood transfusion. Optional techniques, with their specific risks and benefits, were not reviewed with the patient. Chronic pain was not discussed. Complete disclosure must include changes in vulvar ruage and/or vasculature resulting from the placement of incisions or suture. The labia have significant vascularization, frequently resulting in hematoma, making dehiscence a significant risk. Respondent subsequently stated the most common complications were only infection and asymmetry.

77. On or about October 24, 2008, Respondent was repeatedly negligent in his care and treatment of patient K.Q. when he:

(1) Performed a labiaplasty on patient K.Q. without having the necessary training and knowledge to do so;

(2) Combined surgical procedures on K.Q. by performing both an endometrial ablation and a labiaplasty;

(3) Failed to adequately document the surgical procedures performed in the labiaplasty; and

(4) Failed to obtain adequate informed consent from K.Q. regarding the surgeries.

THIRD CAUSE FOR DISCIPLINE

(Medical Record-Keeping)

78. Respondent is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records relating to the provision of services to two patients, thereby committing unprofessional conduct. The circumstances are as follows:

79. Paragraphs 9 through 27 referencing patient C.S. are incorporated herein as if fully set forth.

80. Paragraphs 70 through 76 referencing patient K.Q. are incorporated herein as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Incompetence)

81. Respondent is subject to disciplinary action under section 2234, subdivision (d), of the Code in that he was incompetent in the care and treatment of three patients. The circumstances are as follows:

82. The facts and circumstances alleged in paragraphs 29 through 42 above are incorporated here as if fully set forth.

83. On or about October 25, 2010, in his care and treatment of patient H.M., Respondent demonstrated a lack of knowledge regarding ovarian cysts, the pathogenesis of pelvic adhesions following gynecologic surgery, the etiologies of pelvic pain, abdominal ultrasounds, the

pathophysiology underlying abdominal ultrasounds, the integration of basic knowledge of ovarian physiology into a plan of treatment, the removal of ovaries adherent to the pelvic sidewall, and the diagnostic work-up and treatment plan of pelvic pain.

84. The facts and circumstances alleged in paragraphs 43 through 62 above are incorporated here as if fully set forth.

85. On or about August 7 though August 13, 2011, in his care and treatment of patient C.M., Respondent demonstrated a lack of knowledge about: the diagnosis of appendicitis in pregnancy; the diagnosis and treatment of the acute abdomen; the diagnosis of sepsis; the interpretation of CT findings of free air in the abdomen; the disease process of sepsis and appendicitis post- partum; and the disease process of endometritis.

86. The facts and circumstances alleged in paragraphs 70 through 77 above are incorporated here as if fully set forth.

87. On or about October 24, 2008, in his care and treatment of patient K.Q., Respondent demonstrated a lack of knowledge about the labiaplasty surgical procedure.

DISCIPLINARY CONSIDERATIONS

88. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about March 2, 2006, in a prior disciplinary action entitled In the Matter of the Accusation Against Leonard Sunil Kurian, M.D. before the Medical Board of California, in Case Number 05-2003-145058, Respondent was issued a public letter of reprimand and required to complete a clinical training program, record keeping course and ethics course based on allegations of unprofessional conduct in the care and treatment of a patient. That decision is now final and is incorporated by reference as if fully set forth.

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 70489, issued to Leonard Sunil Kurian, M.D.;

2. Revoking, suspending or denying approval of Respondent's authority to supervise

physician assistants, pursuant to section 3527 of the Code;

3. Ordering Respondent, if placed on probation, to pay the Medical Board of California the costs of probation monitoring; and

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

DATED: April 8, 2014

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

Complainant

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