EDMUND G. BROWN JR.
Attorney General of California
GLORIA L. CASTRO
Supervising Deputy Attorney General
E. A. JONES III
Deputy Attorney General
State Bar No. 71375
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2543
Facsimile: (213) 897-9395
Attorneys for Complainant

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

In the Matter of the Accusation Against: **HOWARD T. PFUPAJENA, M.D.** **12065 Valley Boulevard** **Walnut, California 91789** **Physician's and Surgeon's Certificate No. G 29345** Respondent.	Case No. 11-2007-187599 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Linda K. Whitney (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about May 27, 1975, the Medical Board of California issued Physician's and Surgeon's Certificate Number G 29345 to Howard T. Pfupajena, 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 August 31, 2011, unless renewed.

JURISDICTION

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

to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the 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.

5. Section 2234 of the Code states:

"The Division of Medical Quality[1] 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 [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

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

---

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

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

6. 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."

7. Section 725 of the Code provides as follows:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section."

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

8. Section 2230.5 of the Code provides in relevant part as follows:

"(a) Except as provided in subdivisions (b), (c), and (e), any accusation filed against a licensee pursuant to Section 11503 of the Government Code shall be filed within three years after the board, or a division thereof, discovers the act or omission alleged as the ground for disciplinary action, or within seven years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first.

"....

" (c) An accusation filed against a licensee pursuant to Section 11503 of the Government Code alleging unprofessional conduct based on incompetence, gross negligence, or repeated negligent acts of the licensee is not subject to the limitation provided for by subdivision (a) upon proof that the licensee intentionally concealed from discovery his or her incompetence, gross negligence, or repeated negligent acts."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

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

Factual Allegations re Patient M.B.

A. On or about September 19, 2003, patient M.B. was seen by Respondent at the Eldorado Town House board and care facility, located in Los Angeles, where the patient was a resident. The patient was not referred to Respondent by her primary care physician; the appointment with the patient was set up by a marketing agency used by Respondent to generate patient contacts. According to the patient chart maintained at the board and care facility, which Respondent had access to but did not review, patient M.B. had a history of congestive heart failure (CHF), coronary artery disease (CAD or ASHD), hypertension (HTN), atrial fibrillation, hyperlipidemia and was taking seven medications. There is no evidence of patient consent to treatment by Respondent in either of the patient's charts. Per Respondent's chart,[2] the patient had no history of HTN, seizure disorder, diabetes or ASHD and was only on Haldol. According to Respondent's chart, he performed a physical examination. His impressions were chronic obstructive pulmonary disease (COPD), cough and chronic bronchitis. His treatment plan included pulmonary function test/spirometry. Respondent did not advise the patient's primary care physician of his workup, diagnosis or

[2] Respondent's chart remained in his sole custody and was not made a part of the board and care facility patient chart for patient M.B. Respondent did not make any entries in the board and care facility patient chart for the patient.

treatment plan. Respondent performed and charted a pulmonary function test that showed severe restriction; the tests were not properly performed. Respondent documented a "respiratory therapy evaluation" in which, among other things, he noted that the patient had a non-productive chronic cough and basal rhonchi. His treatment plan was listed albuterol by nebulizer daily for four to six weeks. Respondent also charted a "Respiratory Therapy Progress Notes" form for use in the daily albuterol nebulizer therapy in which he noted the patient had a productive cough.

B. On or about September 22, 23, 24 and 26, 2003; October 6, 7, 8, 10, 13, 14, 15, 17, 20, 21, 22, 24, 27, 28, 29 and 31, 2003; and November 3, 4, 5, 7 and 10, 2003: Respondent charted albuterol nebulizer therapy for patient M.B. in his respiratory therapy progress notes for the patient. Each of the dated entries noted that the patient had a productive cough and that the treatment resulted in improved aeration and was tolerated well.

Allegations of Gross Negligence re Patient M.B.

C. On or about September 19, 2003, Respondent was grossly negligent when he failed to review the patient's chart maintained by the board and care facility or, in the alternative, contact the patient's primary care physician to accurately determine the patient's past medical history.

D. On or about September 19, 2003, Respondent was grossly negligent when he failed to perform a proper pulmonary workup for patient M.B. and/or rule out productive verses non-productive cough.

E. On or about September 19, 2003, Respondent was grossly negligent when he diagnosed patient M.B. with chronic bronchitis without properly ruling out other causes for the chronic cough such as malignancy.

F. On or about September 19, 2003, Respondent was grossly negligent when he failed to administer and evaluate the results of the pulmonary function tests he performed properly.

G. On or about September 19, 2003, Respondent was grossly negligent when he

diagnosed the patient with COPD when the pulmonary function tests indicated the patient had restrictive lung disease.

H. On or about September 19, 2003, Respondent was grossly negligent when he ordered daily albuterol nebulizer treatments, a rescue therapy, for COPD and cough consistent with chronic bronchitis, rather than a long acting beta agonist, a long acting inhaled steroid and/or other similar medications.

Factual Allegations re Patient L.S.

I. On or about October 21, 2003, patient L.S. was seen by Respondent at the Raechelle Care Home board and care facility, located in Los Angeles, where the patient was a resident. The patient was not referred to Respondent by his primary care physician; the appointment with the patient was set up by a marketing agency used by Respondent to generate patient contacts. According to the patient chart maintained at the board and care facility which Respondent had access to but did not review, patient L.S. had a history of schizoaffective disorder and seasonal allergies and was taking five medications, including clozapine, benzotropine mesylate, lithium carbonate and clonazepam. There is no evidence of patient consent to treatment by Respondent in either of the patient's charts. Per Respondent's chart,[3] the patient had no history of HTN, seizure disorder, diabetes or ASHD and no current medications were listed.[4] According to Respondent's chart, he performed a physical examination. His impressions were chronic obstructive pulmonary disease (COPD), cough and chronic bronchitis.[5] His treatment plan included pulmonary function test/spirometry. Respondent did not advise the patient's primary care physician of his workup, diagnosis or treatment plan. Respondent performed and charted a pulmonary function test that showed severe obstruction and moderate restriction; the tests were not

[3] Respondent's chart remained in his sole custody and was not made a part of the board and care facility patient chart for patient L.S. Respondent did not make any entries in the board and care facility patient chart the patient.

[4] This is the same past history listed for patient M.B.

[5] These are the same impressions listed for patient M.B.

properly performed. Respondent documented a "respiratory therapy evaluation" in which, among other things, he noted that the patient had a non-productive chronic cough and rhonchi right. His treatment plan was listed albuterol by nebulizer daily for four to six weeks. Respondent also charted a "Respiratory Therapy Progress Notes" form for use in the daily albuterol nebulizer therapy in which he noted the patient had a productive cough.

J. On or about October 22, 23, 24, 27, 28, 29 and 31, 2003; November 3, 4, 5, 7, 10, 11, 12, 14. 17, 18, 19, 21, 24, 25, 26 and 28, 2003; and December 1 and 2, 2003; Respondent charted albuterol nebulizer therapy for patient L.S. in his respiratory therapy progress notes for the patient. Each of the dated entries noted that the patient had a productive cough and, on almost all dates, bilateral rhonchi and that the treatment resulted in improved aeration and was tolerated well.

Allegations of Gross Negligence re Patient L.S.

K. On or about October 21, 2003, Respondent was grossly negligent when he failed to review the patient's chart maintained by the board and care facility and/or contact the patient's primary care physician to accurately determine the patient's past medical history.

L. On or about October 21, 2003, Respondent was grossly negligent when he failed to perform a proper pulmonary workup for patient L.S. and/or rule out productive verses non-productive cough.

M. On or about October 21, 2003, Respondent was grossly negligent when he diagnosed patient L.S. with chronic bronchitis without properly ruling out other causes for the chronic cough such as malignancy.

N. On or about October 21, 2003, Respondent was grossly negligent when he failed to administer and evaluate the results of the pulmonary function tests he performed properly.

O. On or about October 21, 2003, Respondent was grossly negligent when he ordered daily albuterol nebulizer treatments, a rescue therapy, for COPD and cough consistent with chronic bronchitis, rather than a long acting beta agonist, a long acting

inhaled steroid and/or other similar medications.

Factual Allegations re Patient S.W.

P. On or about October 21, 2003, patient S.W. was seen by Respondent at the Raechelle Care Home board and care facility, located in Los Angeles, where the patient was a resident. The patient was not referred to Respondent by his primary care physician; the appointment with the patient was set up by a marketing agency used by Respondent to generate patient contacts. According to the patient chart which Respondent had access to but did not review maintained at the board and care facility, patient S.W. had a history of hypertension and paranoid schizophrenia and was taking seven medications, including Neurontin, amitriptyline HCL and Haloperidol. There is no evidence of the patient consent to treatment by Respondent in either of the patient's charts. Per Respondent's chart,[6] the patient had no history of HTN, seizure disorder, diabetes or ASHD and no current medications were listed.[7] According to Respondent's chart, he performed a physical examination. His impressions were chronic obstructive pulmonary disease (COPD), cough chronic bronchitis and emphysema.[8] His treatment plan included pulmonary function test/spirometry. Respondent did not advise the patient's primary care physician of his workup, diagnosis or treatment plan. Respondent performed and charted a pulmonary function test that showed very severe obstruction and very severe restriction; the tests were not properly performed. Respondent documented a "respiratory therapy evaluation" in which, among other things, he noted that the patient had a non-productive chronic cough. His treatment plan was listed albuterol by nebulizer daily for four to six weeks. Respondent also charted a "Respiratory Therapy Progress Notes" form for use in the daily albuterol nebulizer therapy in which he noted the patient had a productive cough.

---

[6] Respondent's chart remained in his sole custody and was not made a part of the board and care facility patient chart for patient L.S. Respondent did not make any entries in the board and care facility patient chart for the patient.

[7] This is the same past history listed for patients M.B. and L.S.

[8] But for the emphysema, these are the same impressions listed for patients M.B. and L.S.

Q. On or about October 22, 23, 24, 27, 28, 29 and 31, 2003; November 3, 4, 5, 7, 10, 11, and 12, 2003; Respondent charted albuterol nebulizer therapy for patient S.W. in his respiratory therapy progress notes for the patient. Each of the dated entries noted that the patient had a productive cough and bilateral rhonchi and that the treatment resulted in improved aeration and was tolerated well.

Allegations of Gross Negligence re Patient S.W.

R. On or about October 21, 2003, Respondent was grossly negligent when he failed to review the patient's chart maintained by the board and care facility and/or contact the patient's primary care physician to accurately determine the patient's past medical history.

S. On or about October 21, 2003, Respondent was grossly negligent when he failed to perform a proper pulmonary workup for patient W.S. and/or rule out productive verses non-productive cough.

T. On or about October 21, 2003, Respondent was grossly negligent when he diagnosed patient W.S. with chronic bronchitis without properly ruling out other causes for the chronic cough such as malignancy.

U. On or about October 21, 2003, Respondent was grossly negligent when he failed to administer and evaluate the results of the pulmonary function tests he performed properly.

V. On or about October 21, 2003, Respondent was grossly negligent when he ordered daily albuterol nebulizer treatments, a rescue therapy, for COPD and cough consistent with chronic bronchitis, rather than a long acting beta agonist, a long acting inhaled steroid and/or other similar medications.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

10. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that Respondent engaged in repeated negligent acts in the care and treatment of patients. The circumstances are as follows:

Patient M.B.

A. The facts and circumstances alleged in paragraphs 9.A. and 9.B. above are incorporated here as if fully set forth.

B. On or about September 19, 2003, Respondent was negligent when he failed to obtain and/or document the patient's informed consent to his treatment of the patient.

C. On or about September 19, 2003, Respondent was negligent when he failed to advise the patient's primary care physician of his workup, diagnosis or treatment plan.

D. On or about September 19, 2003, Respondent was grossly negligent when he failed to review the patient's chart maintained by the board and care facility and/or contact the patient's primary care physician to accurately determine the patient's past medical history.

E. On or about September 19, 2003, Respondent was grossly negligent when he failed to perform a proper pulmonary workup for patient M.B. and/or rule out productive verses non-productive cough.

F. On or about September 19, 2003, Respondent was grossly negligent when he diagnosed patient M.B. with chronic bronchitis without properly ruling out other causes for the chronic cough such as malignancy.

G. On or about September 19, 2003, Respondent was grossly negligent when he failed to administer and evaluate the results of the pulmonary function tests he performed properly.

H. On or about September 19, 2003, Respondent was grossly negligent when he diagnosed the patient with COPD when the pulmonary function tests indicated the patient had restrictive lung disease.

I. On or about September 19, 2003, Respondent was grossly negligent when he ordered daily albuterol nebulizer treatments, a rescue therapy, for COPD and cough consistent with chronic bronchitis, rather than a long acting beta agonist, a long acting inhaled steroid and/or other similar medications.

////

Patient L.S.

J. The facts and circumstances alleged in paragraphs 9.I. and 9.J. above are incorporated here as if fully set forth.

K. On or about September 19, 2003, Respondent was negligent when he failed to obtain and/or document the patient's informed consent to his treatment of the patient.

L. On or about September 19, 2003, Respondent was negligent when he failed to advise the patient's primary care physician of his workup, diagnosis or treatment plan.

M. On or about October 21, 2003, Respondent was grossly negligent when he failed to review the patient's chart maintained by the board and care facility and/or contact the patient's primary care physician to accurately determine the patient's past medical history.

N. On or about October 21, 2003, Respondent was grossly negligent when he failed to perform a proper pulmonary workup for patient L.S. and/or rule out productive verses non-productive cough.

O. On or about October 21, 2003, Respondent was grossly negligent when he diagnosed patient L.S. with chronic bronchitis without properly ruling out other causes for the chronic cough such as malignancy.

P. On or about October 21, 2003, Respondent was grossly negligent when he failed to administer and evaluate the results of the pulmonary function tests he performed properly.

Q. On or about October 21, 2003, Respondent was grossly negligent when he ordered daily albuterol nebulizer treatments, a rescue therapy, for COPD and cough consistent with chronic bronchitis, rather than a long acting beta agonist, a long acting inhaled steroid and/or other similar medications.

Patient S.W.

R. The facts and circumstances alleged in paragraphs 9.P. and 9.Q. above are incorporated here as if fully set forth.

S. On or about September 19, 2003, Respondent was negligent when he failed to

obtain and/or document the patient's informed consent to his treatment of the patient.

T. On or about September 19, 2003, Respondent was negligent when he failed to advise the patient's primary care physician of his workup, diagnosis or treatment plan.

U. On or about October 21, 2003, Respondent was grossly negligent when he failed to review the patient's chart maintained by the board and care facility and/or contact the patient's primary care physician to accurately determine the patient's past medical history.

V. On or about October 21, 2003, Respondent was grossly negligent when he failed to perform a proper pulmonary workup for patient W.S. and/or rule out productive verses non-productive cough.

W. On or about October 21, 2003, Respondent was grossly negligent when he diagnosed patient W.S. with chronic bronchitis without properly ruling out other causes for the chronic cough such as malignancy.

X. On or about October 21, 2003, Respondent was grossly negligent when he failed to administer and evaluate the results of the pulmonary function tests he performed properly.

Y. On or about October 21, 2003, Respondent was grossly negligent when he ordered daily albuterol nebulizer treatments, a rescue therapy, for COPD and cough consistent with chronic bronchitis, rather than a long acting beta agonist, a long acting inhaled steroid and/or other similar medications.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

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

A. The facts and circumstances alleged in paragraphs 8 and 9 above are incorporated here as if fully set forth.

////

12. Respondent intentionally concealed from discovery his incompetence, gross negligence and repeated negligent acts set forth above in paragraphs 9, 10 and 11 above by maintaining his charts in his sole custody, by not making his charts a part of the board and care facility patient charts for patients, by not making any entries in the board and care facility patient charts for the patients and by not advising the patients' primary care physicians of his workups, diagnoses or treatment plans.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

13. Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records of the services he provided to patients. The circumstances are as follows:

A. The facts and circumstances alleged in paragraph 8 above are incorporated here as if fully set forth.

B. On or about September 19, 2003, and thereafter, Respondent failed to maintain adequate and accurate records of the services he provided to patients M.B., L.S. and S.W. when he failed to make any notations regarding his workups, diagnoses or treatment plans in the board and care facility chart for the respective patients.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

14. Respondent is subject to disciplinary action under section 2234 of the Code in that Respondent engaged in acts of unprofessional conduct. The circumstances are as follows:

A. The facts and circumstances set forth in paragraphs 8, 9, 10 and 11 are incorporated here 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 29345, issued to Howard T. Pfupajena, M.D.;

2, Revoking, suspending or denying approval of Howard T. Pfupajena, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Howard T. Pfupajena, M.D., 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: December 7, 2010

LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2010504730
50778983.doc