

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

In the Matter of the Accusation Against:)
)
LARS ERIK HANSON, M.D.) Case No. 04-2009-202592
)
Physician's and Surgeon's)
Certificate No. G79925)
)
Respondent.)
_____)

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Medical Board of California, Department of Consumer Affairs, State of California, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on September 8, 2011.

IT IS SO ORDERED August 9, 2011.

MEDICAL BOARD OF CALIFORNIA

By: Shelton Duruisseau
Shelton Duruisseau, Ph.D., Chair
Panel A

1 KAMALA D. HARRIS
Attorney General of California
2 E. A. JONES III
Supervising Deputy Attorney General
3 JUDITH T. ALVARADO
Deputy Attorney General
4 State Bar No. 155307
300 South Spring Street, Suite 1702
5 Los Angeles, California 90013
Telephone: (213) 576-7149
6 Facsimile: (213) 897-9395
Attorneys for Complainant

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

12 In the Matter of the Accusation Against:

Case No. 04-2009-202592

13 LARS ERIK HANSON, M.D.
14 745 East Valley Boulevard, PMB 252
San Gabriel, California 91776

OAH No. 2010100273

15 Physician's and Surgeon's Certificate
16 No. G 79925,

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

17 Respondent.

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

21 PARTIES

22 1. Linda K. Whitney (Complainant) is the Executive Director of the Medical Board of
23 California. She brought this action solely in her official capacity and is represented in this matter
24 by Kamala D. Harris, Attorney General of the State of California, by Judith T. Alvarado, Deputy
25 Attorney General.

26 2. Respondent LARS ERIK HANSON, M.D. is represented in this proceeding by
27 attorney Joseph P. Furman, Esq., of Furman Healthcare Law, whose address is: 9701 Wilshire
28 Boulevard, 10th Floor, Beverly Hills, California 90212.

1 CULPABILITY

2 8. Respondent admits that at a hearing, Complainant could set forth a prima facie case
3 for unprofessional conduct as alleged in Accusation No. 04-2009-202592, and Respondent
4 declines to defend same in this matter. Respondent further agrees that his Physician and
5 Surgeon's Certificate is subject to discipline for violation of Business and Professions Code 2234
6 (a) and he agrees to be bound by the Board's imposition of discipline as set forth in the
7 Disciplinary Order below.

8 RESERVATION

9 9. The admissions made by Respondent herein are only for the purposes of this
10 proceeding, or any other proceedings in which the Medical Board of California or other
11 professional licensing agency is involved, and shall not be admissible in any other criminal or
12 civil proceeding.

13 CONTINGENCY

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

24 11. The parties understand and agree that facsimile copies of this Stipulated Settlement
25 and Disciplinary Order, including facsimile signatures thereto, shall have the same force and
26 effect as the originals.
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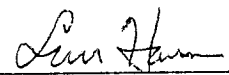
Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. **MEDICAL and PSYCHIATRIC EVALUATION**

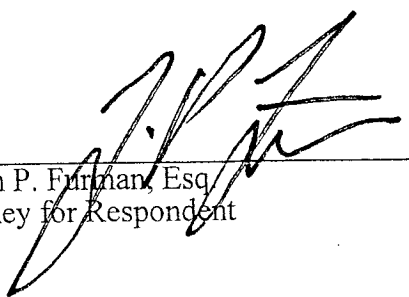
Condition successfully satisfied.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Joseph P. Furman, 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: 5/7/2011 
LARS ERIK HANSON, M.D.
Respondent

I have read and fully discussed with Respondent LARS ERIK HANSON, 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: May 9, 2011 
Joseph P. Furman, 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 of the Department of Consumer

Affairs. ⁹
Dated: May ^A, 2011

Respectfully submitted,

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



JUDITH T. ALVARADO
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 04-2009-202592

1 EDMUND G. BROWN JR.
2 Attorney General of California
3 JUDITH T. ALVARADO
4 Deputy Attorney General
5 State Bar No. 155307
6 300 South Spring Street, Suite 1702
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10 *Attorneys for Complainant*

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

In the Matter of the Accusation Against:

Case No. 04-2009-202592

LARS ERIK HANSON, M.D.
745 East Valley Blvd., PMB 252
San Gabriel, California 91776

ACCUSATION

Physician's and Surgeon's Certificate
No. G 79925,

Respondent.

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 (Board).

2. On or about September 28, 1994, the Board issued Physician's and Surgeon's Certificate number G 79925 to Lars Erik Hanson, M.D. (Respondent). That certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2011, 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 ("Code") unless otherwise indicated.

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

5 5. Section 2234 of the Code states:

6 "The Division¹ of Medical Quality shall take action against any licensee who is
7 charged with unprofessional conduct. In addition to other provisions of this article,
8 unprofessional conduct includes, but is not limited to, the following:

9 "(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting
10 the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the
11 Medical Practice Act]."

12 "(b) Gross negligence."

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

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

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

24 “...”

25
26 ¹ California Business and Professions Code section 2002, as amended and effective
27 January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in
28 the State Medical Practice Act (Cal. Bus. & Prof. Code, §§§§ 2000, et seq.) means the "Medical
Board of California," and references to the "Division of Medical Quality" and "Division of
Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Gross Negligence)**

3 **(Failure to Properly Maintain and Operate an Abortion Clinic)**

4 6. Respondent has subjected his Physician's and Surgeon's certificate to disciplinary
5 action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in
6 that he committed gross negligence in his maintenance and operation of an outpatient abortion
7 clinic, as more particularly alleged herein:

8 7. On or before December 1, 2000, Respondent leased office space at 789 South San
9 Gabriel Boulevard, Suite E, in the city of San Gabriel, California. On or about December 1,
10 2000, Respondent sub-leased a portion of the office space to Feng Jie Yuan, an acupuncturist.

11 8. On or before June 22, 2009, Respondent opened and operated an abortion clinic in the
12 office space he leased at 789 South San Gabriel Boulevard, Suite E, in the city of San Gabriel,
13 California. Respondent advertised his abortion clinic as "Clinica Para La Mujer" on an awning
14 over the door of the clinic. Respondent also advertised his abortion clinic in the 2008 and 2009
15 editions of the Chinese Consumer Yellow Pages. Respondent's Yellow Pages advertisements
16 were listed under the heading "Doctor-Abortion Services" and his clinic was identified as a
17 Family Planning Medical Center which provided "induced abortion and surgical operation
18 induced abortion, special price \$286 (Excluding anesthetic fee)."

19 9. The standard of medical practice for an outpatient abortion clinic is to provide safe,
20 legal and accessible abortion care. In so doing, the clinic must be adequately staffed with
21 licensed nurses, nurse anesthetists or anesthesiologists, physicians, counselors or other personnel
22 trained in abortion care. At least one staff member of the healthcare team must maintain a current
23 CPR (cardiopulmonary resuscitation) certificate for emergency care whenever an abortion is
24 being performed. Further, the clinic must be adequately equipped to provide abortion care. This
25 includes functioning equipment, sterile instruments, and medications. All patients who have
26 undergone a surgical abortion must be observed during the recovery period by a health care
27 worker trained in postoperative care. The clinic must provide an emergency contact service on a
28 24 hour basis; the clinic must assure physician referral if indicated. Finally, the clinic must have

1 appropriate equipment and medications on site to handle medical emergencies, including an
2 oxygen delivery system, oral airways, uterotonics² and epinephrine.

3 10. Respondent's abortion clinic was not adequately staffed to provide abortion care or
4 perform surgical procedures. Respondent did not employ any licensed nurses, nurse anesthetists
5 or anesthesiologists, counselors or other personnel trained in abortion care. Respondent's only
6 clinic staff member is his wife, An Li Chaing, who has no medical training.

7 11. Respondent did not have a current certified CPR provider at his clinic while abortions
8 were performed.

9 12. The equipment in Respondent's clinic was inadequate to perform adequate pre-
10 abortion testing, such as accurate ultrasound dating of the pregnancy.

11 13. Respondent maintained expired medications in his clinic.

12 14. Respondent maintained non-sterile medical instruments in his clinic.

13 15. Respondent's clinic did not have an appropriate setting for the recovery of patients
14 and Respondent did not employ a health care worker trained in postoperative care.

15 16. Respondent did not have a 24 hour emergency contact service or physician referral
16 system. Indeed, the physician Respondent contracted with to provide abortion services only came
17 to his clinic once a week.

18 17. Respondent's clinic was inadequately equipped for emergencies and resuscitation.

19 18. Respondent's conduct as set forth above includes the following acts and/or omissions
20 which constitute an extreme departure from the standard of practice.

21 A. His failure to adequately staff his abortion clinic.

22 B. His failure to adequately equip his clinic to safely perform surgical abortions.

23 C. His failure to provide adequate postoperative care.

24 D. His failure to adequately prepare his clinic for management of abortion
25 emergencies.

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27 _____
28 ² Medications to treat heavy uterine bleeding.

1 19. Respondent's acts and/or omissions as set forth in paragraphs 7 through 18, inclusive,
2 above, whether proven individually, jointly, or in any combination thereof, constitute gross
3 negligence pursuant to section 2234 (b) of the Code. Therefore cause for discipline exists.

4 **SECOND CAUSE FOR DISCIPLINE**

5 **(Gross Negligence)**

6 **(Unprofessional Conduct)**

7 20. On or about July 28, 2009, at approximately 11:00 a.m., Patient Y.C.³, a 30-year-old
8 woman, presented for her scheduled appointment at Respondent's clinic for the purpose of having
9 an abortion.

10 21. Respondent had prearranged with Andrew Rutland, M.D. that Dr. Rutland would
11 perform the abortion on Y.C.

12 22. Dr. Rutland performed a history and physical on Y.C. Respondent and Dr. Rutland
13 performed an ultrasound on Y.C. for the purpose of estimating the gestational age of the fetus.
14 Based on the physical examination and ultrasound, Dr. Rutland estimated the gestational age at
15 16 to 16.5 weeks. Thereafter, Dr. Rutland performed a pelvic examination on Y.C. He then gave
16 patient Y.C. a paracervical block⁴ with lidocaine.

17 23. Shortly after receiving the paracervical block, patient Y.C. began to have a reaction.
18 Respondent and acupuncturist, Mr. Yuan, were called into the procedure room and the three
19 began performing CPR on Y.C.

20 24. An Li Chiang called 911 and paramedics were dispatched at 1:19 p.m. Emergency
21 personnel (paramedics) arrived on the scene at approximately 1:20 p.m. and patient Y.C. was
22 found to be in full cardiac arrest. The paramedics observed that neither Respondent nor Dr.
23 Rutland were providing any care to patient Y.C.

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25 _____
26 ³ In this Accusation, the patient is referred to by initial. The patient's full name will be
disclosed to Respondent when discovery is provided pursuant to Government Code section
27 11507.6

28 ⁴ Regional anesthesia resulting from the injection of local anesthetic to the cervix used to
provide analgesia during gynecological procedures.

1 25. The paramedics requested the assistance of the San Gabriel Police Department as they
2 noted the presence of a shirtless male running inside the clinic. The "shirtless male" was later
3 identified as Respondent. The responding officer, Officer Cortez, advised Respondent that he
4 needed to question him regarding patient Y.C. Nevertheless, Respondent entered his vehicle and
5 proceeded to drive away. A second officer was called to intercept Respondent and return him to
6 the clinic.

7 26. Once Respondent returned to the clinic, he refused to cooperate with the San Gabriel
8 Police Department's investigation of the circumstances surrounding patient Y.C.'s cardiac arrest.
9 Respondent's behavior was described as irrational and excited. Respondent refused to provide
10 accurate information to the police and insisted that he could not recall what had occurred with
11 regard to patient Y. C.

12 27. Paramedics performed life saving measures and took patient Y.C. to the San Gabriel
13 Medical Center where she died six days later.

14 28. An autopsy determined that the cause of Y.C.'s death was sequelae of
15 anoxic/ischemic encephalopathy as a consequence of cardiopulmonary arrest due to lidocaine
16 toxicity. Y.C.'s death was classified by the Los Angeles County Coroner as a homicide.

17 29. Respondent's conduct as set forth above includes the following acts and/or omissions
18 which constitute an extreme departure from the standard of practice.

19 A. His lack of professionalism.

20 30. Respondent's acts and/or omissions as set forth in paragraphs 20 through 29,
21 inclusive, above, whether proven individually, jointly, or in any combination thereof, constitute
22 gross negligence pursuant to section 2234 (b) of the Code. Therefore cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

25 31. Respondent is subject to disciplinary action under section 2234, subdivision (c) of the
26 Code in that his conduct and his care and treatment of patient Y.C. constituted repeated negligent
27 acts. The circumstances are as follows:

28 ///

1 32. The allegations of the First Cause for Discipline are incorporated herein by reference
2 as if fully set forth.

3 33. The allegations of the Second Cause for Discipline are incorporated herein by
4 reference as if fully set forth.

5 **Patient Y.C.**

6 34. As noted above, after receiving the paracervical block, patient Y.C. began to have a
7 reaction. Respondent was called into the procedure room and began to administer CPR to Y.C.
8 by providing respirations. Apparently, Y.C. vomited on Respondent, causing Respondent to
9 panic and run out of the procedure room, prior to the arrival of the paramedics.

10 35. The standard of care calls for a physician to provide basic life support (CPR) to a
11 patient until emergency service personnel arrive and assume care of the patient.

12 36. Respondent's conduct as set forth above includes the following acts and/or omissions
13 which constitute departures from the standard of practice.

14 A. His failure to adequately staff his abortion clinic.

15 B. His failure to adequately equip his clinic to safely perform surgical abortions.

16 C. His failure to provide adequate postoperative care.

17 D. His failure to adequately prepare his clinic for management of abortion
18 emergencies.

19 E. His lack of professionalism.

20 F. His failure to continue to provide basic life support to patient Y.C. until
21 transferring her care to paramedics.

22 37. Respondent's acts and/or omissions as set forth in paragraphs 32 and 36, inclusive,
23 above, whether proven jointly, or in any combination thereof, constitute repeated negligent acts
24 pursuant to section 2234 (c) of the Code. Therefore, cause for discipline exists.

25 **PRAYER**

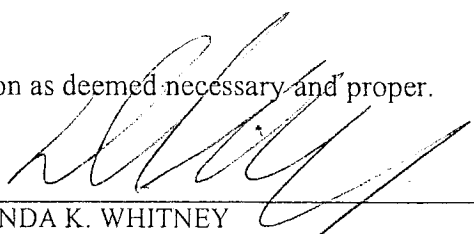
26 **WHEREFORE**, Complainant requests that a hearing be held on the matters herein alleged,
27 and that following the hearing, the Medical Board of California issue a decision:

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1. Revoking or suspending Physician's and Surgeon's Certificate No. G 79925 issued to Lars Erik Hanson, M.D.;
2. Ordering him to pay the Board, if placed on probation, the costs of probation monitoring;
3. Prohibiting him from supervising physician assistants pursuant to section 3527 of the Code; and
5. Taking such other and further action as deemed necessary and proper.

DATED: August 12, 2010



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