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

In the Matter of the Accusation Against:	
KIM BEAUCHAMP, M.D. 10150 Olivia Terrance Sun Valley, California 91352	No. 11-93-24972 OAH No. L-9510113
Physician's and Surgeon's Certificate No. A24496	
Physician's Assistant Supervisor License No. SA20917,	
Respondent.	

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Medical Board of California as its Decision in the above-entitled matter.

This Decision shall become effective on September 19, 1997.

IT IS SO ORDERED August 21, 1997.

MEDICAL BOARD OF CALIFORNIA
DIVISION OF MEDICAL QUALITY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____

btm

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Respondent.	

PROPOSED DECISION

This matter came on regularly for hearing before Ralph B. Dash, Administrative Law Judge with the Office of Administrative Hearings, on April 28, 29 and 30 and May 1, 6, 7, 8, 9, 12, 13 and 14, 1997 at Los Angeles, California.

Complainant was represented by Karen Chappelle, Deputy Attorney General.

Respondent was present and was represented by Philip L. Nadler, Attorney at Law.

The record was originally left open until June 9, 1997 for receipt of closing and reply briefs. This date was extended for a period of two weeks for good cause shown. Each party timely filed a post trial brief and the matter was deemed submitted on June 27, 1997.

Oral and documentary evidence having been received and the matter submitted, the Administrative Law Judge makes the following Findings of Fact:

* * * * *

1. Complainant Ron Joseph made the First Amended and Supplemental Accusation (the operative pleading herein, referred

to hereinafter as the "Accusation") in his official capacity as Executive Director of the Medical Board of California (the "Board").

2. On September 17, 1971, the Board issued Physician and Surgeon's Certificate No. A24496 to Respondent Kim Beauchamp. At all times relevant hereto, said certificate has been and is now in full force and effect, with an expiration date of November 30, 1998. Respondent has also been approved by the Board as a supervisor of a physician assistant, approval No. SA 20917; however, said approval has been in delinquent status since November 30, 1995.

3. At the trial of this matter, numerous expert and other witnesses were called, prior recorded testimony of others was introduced, and a plethora of reports, records and documents was received, read and considered. In making the Findings herein, the Administrative Law Judge was guided by the following principles relating to the standard of proof to be used in professional license disciplinary proceedings:

The standard of proof which must be met to establish the charging allegations of the Accusation is "clear and convincing" evidence. Ettinger v. Board of Medical Quality Assurance, 135 Cal.App.3d 853 (1982). This means the burden rests on Complainant to offer proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. In re Marriage of Weaver, 224 Cal.App.3d 478 (1990).

4. Respondent is an obstetrician/gynecologist by training who, for most of his medical career, has specialized in performing low cost therapeutic abortions. The Accusation alleges several grounds upon which discipline should be imposed. The most serious charges involve two unrelated patients: C.A., who Respondent saw while he was employed at an abortion clinic, and G.M., a long time ob/gyn patient of Respondent. The charging allegations of the Accusation are dealt with below in the order in which they appear in the pleadings.

PATIENT C.A.

5. On October 24, 1992, at approximately 12:30 p.m., C.A., then 19 years old, went to Clinica Femenina para la Mujer de Hoy Grupo Medico (the "clinic"), an authorized fictitious name of Respondent, located at 453 South Spring Street, Los Angeles, California. The clinic itself was owned by Carmen Moreno, who employed Respondent and paid him on a per patient basis, depending upon the services he rendered. C.A. had seen an ad for the clinic (under the name "Clinica Latina"), and believing she might be pregnant, went there for a free pregnancy test and, if

found pregnant, a low cost abortion. The clinic was also advertised under the name "Clinica Latina Feminina". Neither of these latter two clinic names were authorized fictitious names of Respondent.

6. What transpired at the clinic was the subject of much conflicting evidence, including both percipient and expert witnesses, and hundreds of pages of medical records. Virtually the only issue not in dispute regarding C.A is that approximately eight hours after she first arrived at the clinic, she delivered an approximately 25 week old baby girl by emergency cesarean section at Women's Hospital in Los Angeles.

According to C.A.'s testimony, upon arrival at the clinic, she was taken to an examination room and told to undress from the waist down. Fifteen minutes later she was given a shot in the arm. Respondent entered the room shortly thereafter, talking to another person. Respondent performed a brief manual exam, then immediately commenced an abortion procedure by placing a catheter attached to a suction machine through C.A.'s vaginal opening and having the suction machine turned on. She saw blood and fluid run through the clear tubing into the machine. Respondent stopped the procedure shortly after he started it, exclaiming the baby was too big, stating "My God, what have I done" while bumping his head against the wall. Respondent left the room and a male nurse entered and hurried her out of the clinic. She was bleeding but was given no instructions, prescriptions or advice. She denied having had an ultra sound at the clinic.

7. Respondent's version of what transpired with C.A. is markedly different. Without going into each variant, Respondent claims he performed a bi-manual pelvic exam on C.A., followed by insertion of a speculum, at which time he determined the fetus to be between 23 to 25 weeks old. He remarked, "My God, what are you trying to do here, the baby is too big" and thus took no steps to perform an abortion. He determined C.A. was in premature labor, gave her a prescription for Terbutalin (used to stop contractions), advised her to go to Women's Hospital immediately and took an ultrasound to "satisfy [his] own curiosity" about the baby's age. He denied he took any steps whatsoever to perform an abortion. He admitted he did not listen to C.A.'s heart during the time he spent with her and it was his then practice not to listen to the heart of a patient, even if he were to perform an abortion. He also admitted he did not perform an examination of C.A.'s ears, eyes, nose, throat or chest, although his chart notations indicated he had done so.

8. After she left the clinic, C.A. went to St. George Ambulatory Care Center to visit a relative. While there she felt ill, was examined by a doctor and was advised to go immediately to Women's Hospital, which she did. Hospital records show that C.A. presented at Women's Hospital completely dilated and effaced, with a "bulging bag" (the amniotic sac filled with fluid visible at the head of the birth canal). A classical C-section was performed on an emergency basis. The baby showed signs of bruising. The infant died less than three days later; however, it is not charged that Respondent's alleged conduct in any way caused the death.

9. As with the percipient witnesses, the experts also disagreed over what transpired at the clinic. Their testimony was based upon review of all available medical records. Complainant's expert, well respected and excellently credentialed, testified it is possible for the amniotic sac to be ruptured, then sealed by the fetus having turned to a point where a body part, such as the buttocks, would abut the rupture. The bruising, he stated, could be caused by the interrupted abortion, and not by the delivery. Thus, he concluded, the medical records were consistent with C.A.'s testimony.

Respondent's expert, also highly regarded in his field and with vast experience, opined it would be impossible for the amniotic sac to have been ruptured by a suction catheter (which would cause an immediate release of most of the amniotic fluid) and have C.A. present 8 hours later with a bulging amniotic sac. The rupture would be so abrupt and large, the fetus could not seal it off, and there would not be enough time for the fluid to regenerate to the extent it would cause the sac to bulge. The bruising of the baby, judging by its nature and extent, was caused by manual manipulation during delivery and not by an attempted abortion. Thus, he concluded, the medical records were consistent with Respondent's version of what transpired at the clinic.

10. Several witnesses described in exhaustive detail the manner and means by which first trimester therapeutic abortions are performed--the technique for which Respondent is alleged to have started on C.A., even though she was then beginning her third trimester. Part of the procedure requires prior artificial dilation of the cervix, usually by use of laminaria. These are short, thin, rod-like devices often made of seaweed, which are inserted through a speculum and into the cervix. They swell due to secretion of body fluids, causing the cervix to dilate. They are then removed and a suction catheter is inserted, the sharp tip causing a puncture and rupture of the sac. The high negative pressure of the suction removes the contents of the womb.

As the fetus develops, the manner in which abortions are performed changes. While it is not necessary to detail the differences, the experts agreed the instruments used and patient preparation are markedly different in later term abortions. The experts also agreed it is well beyond the standard of care for a doctor performing a therapeutic abortion not to distinguish between a twelve week old fetus and twenty-five week old fetus. They also agreed it is well beyond the standard of care to not prepare the patient for and perform the procedure using the techniques designed for the specified fetal age.

11. C.A.'s testimony was at first compelling, but extrinsic evidence cast some doubt on parts thereof. C.A. was adamant Respondent commenced the abortion almost immediately, with no prior warning, by inserting the suction catheter directly. This could not have been done unless she were first dilated, and the speculum inserted, through which the catheter would be passed.

C.A. was very familiar with ultrasound, having undergone the same at least ten times (during an earlier pregnancy), and emphatically denied having had ultrasound at the clinic. However, during an unannounced visit by a Board investigator to the clinic, and before Respondent was made aware of her complaint, C.A.'s original chart was produced by Respondent. The chart contained an ultra sound image of a fetus approximately 25 weeks of age. Furthermore, less than 48 hours after delivery, C.A. had a lengthy conversation with a Resident at Women's Hospital. At that time, C.A. stated Respondent had ordered an ultrasound which was performed.

C.A. told the Resident at Women's Hospital Respondent had given her a prescription for Terbutalin. She denied this on the witness stand. The clinic records showed C.A. to have rh positive blood, which could only be ascertained after a simple blood test was performed. C.A. denied this was done. Finally, C.A. denied anyone at the clinic had taken her heart rate or blood pressure; however, the clinic records show this was done and the readings were virtually identical with those taken at St. George a short time later.

12. Taking all of the foregoing into consideration, it is found that Complainant has not established by clear and convincing evidence Respondent actually commenced, then stopped, a suction catheter abortion procedure on C.A. Her presentation at Women's Hospital with a "bulging bag" is inconsistent with the attempted procedure. The sharp tip of the catheter and the relative strength of the suction would cause an immediate rupture of the amniotic sac and loss of most of the amniotic fluid. Although perhaps medically possible for the fetus to have turned in such a position it could have sealed a rupture, the extent of the rupture caused by a suction catheter would make it highly

improbable to have done so. Additionally, there would not be enough amniotic fluid to cause the now re-sealed bag to "bulge" eight hours later. This, coupled with the many inaccuracies in C.A.'s testimony, precludes a finding by clear and convincing evidence that Respondent commenced, then stopped before completion, the abortion procedure as alleged in the First Cause of Action of the Accusation.

PATIENT G.M.

13. G.M., a young woman, was a regular patient of Respondent, having seen him at his Panorama City office on numerous occasions for both obstetrics and gynecology since at least October, 1985. On June 20, 1986, Respondent delivered G.M.'s first child by Cesarean section.

14. On August 28, 1987, G.M. visited Respondent and complained of pain in her right breast. On examination, Respondent discovered a small lump, approximately the size of a grape. Respondent ordered a mammogram, which was performed on September 1, 1987. The clinical history on the mammogram report referred to "right breast mass". It showed no radiographic evidence of carcinoma. Respondent's nurse informed G.M. the lump was probably dried breast milk. Respondent neither offered nor performed any follow up care regarding the lump in G.M.'s breast.

15. Respondent next saw G.M. on June 8, 1988. She again complained of pain in her breast and was personally able to palpate the same. Respondent offered no care or treatment for the palpable lump. At that time, Respondent removed an intrauterine device from G.M., who became pregnant shortly thereafter. Respondent followed G.M.'s pregnancy, seeing her on a monthly or more frequent basis, and delivered her second child in March, 1989. Each time she saw Respondent, G.M. complained of the pain in her breast. Respondent offered no care or treatment for the same.

16. On May 10, 1989, Respondent again examined G.M, who still complained of pain in her breast. Respondent offered no care or treatment therefor. On August 9, 1989, Respondent again examined G.M., who was still complaining of pain in her breast. By this time, the lump had grown almost to the size of a baseball. G.M.'s entire breast had become hard. Respondent ordered another mammogram, which was taken the next day. It showed a mass "suspicious for malignancy". By this time, the cancer was to such an advanced stage, mastectomy was not a viable alternative. G.M. died of cancer approximately eighteen months later at age 28.

17. According to all expert testimony, the standard of care in the medical community in 1987, when Respondent first discovered the lump in G.M.'s breast, was for Respondent to have ordered or performed a needle biopsy and excision of the lump, even in light of the negative mammogram. This is due in large part to the ten to fifteen per cent "false negative" rates in mammograms, as well as the potential lethal consequences for failure to promptly treat breast cancer.

18. By the time of trial, Respondent was well aware of the appropriate standard of care and so testified. Respondent was apparently not aware of the standard of care in 1987, since he failed to follow the same. It is most likely for this reason Respondent falsified his medical records of G.M. for the visit of August 28, 1987, the visit when the lump was first discovered. Respondent destroyed the original chart for this date, and substituted a false original, which contained a reference to "increased nodularity" in G.M.'s breast, in place of what presumably read "right breast mass", or words to that effect. The falsification was a blatant act of dishonesty, and Respondent's "explanation" therefor found to be nothing more than corruption. Respondent's misconduct was brought to light as follows:

Prior to her death, G.M. had filed a civil action for damages against Respondent, who represented himself, his malpractice insurance having lapsed. Discovery was undertaken and G.M.'s medical records were requested from Respondent. Respondent permitted copies to be made in December, 1990. G.M.'s attorney examined the documents and discovered the entry for August 28, **1987** was written on medical note paper, provided gratis by a pharmaceutical fulfillment company, which carried a vitamin advertisement with a **1989** copyright date. Further investigation showed the note paper was in fact not in existence in 1987, and was not sent to Respondent any time sooner than March of 1989.

At his deposition, Respondent was asked on numerous occasions whether he had re-copied the chart for the August 28, 1987 visit, or whether he had falsified any documents. He denied having done so. In her deposition, Respondent's nurse, whose handwriting was also on the chart for the date in question, also denied having re-written the same. Respondent was given ample opportunity to correct his deposition testimony--he was specifically advised he could do so, but did not. At that time he could offer no explanation for the fact the chart could not have been written in 1987 since the paper on which it was written was not even in existence until 1989. The attorney notified the Board of Respondent's misconduct after Respondent agreed to settle what had by then become a wrongful death action for the sum of $100,000, then immediately filed for bankruptcy.

At the trial of this matter, Respondent offered a wholly unconvincing (and often internally inconsistent) explanation of what happened. According to Respondent, the original chart page had been torn in half. Just how he could not explain; nor could he explain why none of the other pages in the chart had been torn or why the original could not have been simply taped together. After being notified the records had been requested, Respondent and his nurse re-copied the chart "word for word" and substituted the copy for the original, which he threw away. When his deposition was taken a few months later (in April 1991), he had "forgotten" he had re-copied the chart.

The particular page Respondent "copied" was of great significance because it was at the August 28, 1987 Respondent first discovered the lump in G.M.'s breast. However, the chart as "re-copied" by Respondent shows only a notation of "increased nodularity" in the breast--not a lump. Nodularity in the large breasts of a young healthy woman such as G.M.is quite common, and should not have been a cause for great concern by Respondent. Nevertheless, the remainder of the actual original chart shows Respondent did have some concern. He ordered an immediate mammogram after the August 28, 1987 visit, and the clinical history on the report, which most likely came from Respondent's office inasmuch as his office set up the procedure, showed G.M. to have a "right breast mass".

The only reasonable explanation for Respondent's conduct is that the original chart did in fact show Respondent had discovered the lump, and that Respondent relied on the negative mammogram for his later conduct (or rather "non-conduct") instead of following the standard of care by performing or ordering a needle biopsy and excision. Respondent thus elevated his initial act of gross negligence, and his continued acts of gross negligence in failing to offer the appropriate care, into corrupt and dishonest conduct by his falsification of the chart.

19. Respondent offered no credible explanation for <u>any</u> of his conduct set forth in each of the foregoing Findings.

20. In connection with the investigation and prosecution of this action, the Board incurred expenses, including charges by the Attorney General, in the total sum of $50,202.29. Although as set forth in the Determination of Issues, Complainant will not prevail on the major issues related to patient C.A., the expenses were all reasonably incurred.

The Board certainly had cause to investigate the allegations made by C.A. Respondent's cavalier attitude toward the investigation only exacerbated the Board's reasonable concerns. As an example, when Board investigators sent Respondent a questionnaire that asked at what point he had

ordered the ultrasound on C.A. (which he had in fact done), he denied he had done so. When he was interviewed by Board investigators, Respondent explained the discrepancy by stating he hadn't paid much attention to the questionnaire, he was busy with other matters, he did not have the records in question and essentially couldn't be bothered with it.

At trial, Respondent claimed he hadn't paid much attention to the questions asked at his personal interview (which went on for more than 2 hours) either, which is why, he said, there were so many discrepancies--far too many to list--between his statements to the Board and his testimony at trial. This lack of cooperation succeeding in impeding the investigation, causing much delay and greater expense. Respondent in general displayed a remarkable disregard for the Board and its processes.

* * * * *

DETERMINATION OF ISSUES

1. In connection with his treatment of C.A., Respondent committed repeated acts of negligence and incompetence by making entries in her chart showing he had examined her heart, ears, eyes, nose, throat and chest, when he had in fact not done so, as set forth in Findings 7 and 19, thereby subjecting his license to discipline under the provisions of Business and Professions Code Sections 2234 (c) and (d)

2. In connection with his treatment of G.M., Respondent committed repeated acts of gross negligence and incompetence by his failure to order or perform a needle biopsy on the lump in her right breast which Respondent discovered on August 28, 1987, and by his continued failure to offer any treatment therefor, despite repeated re-examination of the patient, who continued to complain, as set forth in Findings 14-17 and 19, thereby subjecting his license to discipline under Business and Professions Code Sections 2234 (b) and (c).

3. Respondent's falsification of G.M.'s chart, as set forth in Finding 18, is a direct violation of Business and Professions Code Section 2262. It is also an act of dishonesty and corruption which is substantially related to the functions, duties and qualifications of a Board licensee, a violation of Business and Professions Code Section 2234 (e). See generally, Windham v. Board of Medical Quality Assurance, 104 Cal.App.3d 461, which in holding the crime of income tax evasion was one of moral turpitude and substantially related to the functions, duties and qualifications of a physician stated, at page 470:

"...we find it difficult to compartmentalize dishonesty....Above all...there is the relation between doctor and patient. It is unnecessary to describe the extent to which that particular relationship is based on utmost trust and confidence in the doctor's honesty and integrity...intentional dishonesty...demonstrates a lack of moral character and satisfies a finding of unfitness to practice medicine."

Respondent's conduct here is far more egregious than that described in Windham, since it directly involves the falsification of medical records.

4. Respondent's use of unauthorized fictitious names in newspaper advertisements, as set forth in Findings 5 and 19, constitutes unprofessional conduct within the meaning of Business and Professions Code Section 2272.

5. The Board reasonably incurred costs of investigation and prosecution of this action in the total sum of $50,202.29, by reason of Finding 20, and is entitled to recover the same from Respondent under the provisions of Business and Professions Code Section 125.3.

6. Except as expressly found in the foregoing Determinations to have been proven, the remaining charging allegations of the Accusation are determined to have been unproven by clear and convincing evidence.

* * * * *

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

1. Physician and Surgeon's Certificate No. A24496 and Supervisor for Physician Assistants License No. SA20917, together with all licensing rights appurtenant thereto, issued to Respondent Kim Beauchamp, are revoked.

2. Respondent Kim Beauchamp is ordered to pay to the Medical Board of California the sum of $50,202.29 as and for the recovery of its reasonable costs incurred in the investigation and prosecution of the within action.

Date: 7-30-97

RALPH B. DASH
Administrative Law Judge

DANIEL E. LUNGREN, Attorney General
of the State of California
KAREN B. CHAPPELLE,
Deputy Attorney General
California Department of Justice
300 South Spring Street, Suite 5212
Los Angeles, California 90013-1204
Telephone: (213) 897-2575

Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
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In the Matter of the Accusation Against:	NO. 11-93-24972
KIM BEAUCHAMP, M.D. 10150 Olivia Terrace Sun Valley, California 91352 Physician and Surgeon's Certificate No. A24496, Supervisor of Physician Assistants License No. SA20917, Respondent.	A C C U S A T I O N

Complainant alleges:

PARTIES

1. Complainant, Doug Laue, Acting Executive Director of the Medical Board of California (hereinafter the "Board") and brings this accusation solely in his official capacity.

2. On or about September 17, 1971, Physician and Surgeon's Certificate No. A24496 was issued by the Board to Kim

Beauchamp, M.D. (hereinafter "respondent"), and at all times relevant to the charges brought herein, this license has been in full force and effect. Unless renewed, it will expire on October 30, 1996. Dr. Beauchamp is a supervisor of a physician assistant. His physician assistant license number SA20917 is valid and unless renewed expires on November 30, 1995.

JURISDICTION

3. This accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the California Business and Professions Code (hereinafter "Code"):

A. Sections 2003 and 2004 which provide, in pertinent part, that that the Division is responsible for the enforcement of the disciplinary provisions of the Medical Practices Act, for the administration and hearing of disciplinary actions, for carrying out disciplinary actions appropriate to findings made by a medical quality review committee, and revoking or otherwise limiting certificates after the conclusion of disciplinary actions.

B. Section 2220 which provides:

"Except as otherwise provided by law, the Division of Medical Quality may take action against all persons guilty of violating this chapter. The division shall enforce and administer this article as to physician and surgeon certificate holders, and the division shall have all the powers granted in this chapter for these

purposes including, but not limited to:

"(a) Investigating complaints from the public, from other licensees, from health care facilities, or from a division of the board that a physician and surgeon may be guilty of unprofessional conduct.

"(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

"(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon."

C. Section 2227 which provides:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in section 11371 of the Government Code, or whose default has been entered, and who is found guilty may, in accordance with the provisions of this chapter.

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

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

(3) Be placed on probation upon order of the division.

(4) Be publicly reprimanded by the division.

(5) Have any other action taken in relation to discipline as the division or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board."

D. Section 2234 which provides:

"The Division of Medical Quality 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, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(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."

E. Section 2264 which provides:

"The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

F. Section 2272 which provides:

"Any advertising of the practice of medicine in which the licensee fails to use his or her own name or approved fictitious name constitutes unprofessional conduct."

G. Section 2415 of the Code which provides:

"(a) Any physician and surgeon or any doctor of podiatric medicine, as the case may be, who as a sole proprietor, or in a partnership, group, or professional corporation, desires to practice under any name that would otherwise be a violation of Section 2285 may under that name if the proprietor, partnership, group,

or corporation obtains and maintains in current status a fictitious-name permits issued by the Division of Licensing or, in the case of doctors of podiatric medicine, the California Board of Podiatric Medicine, under the provisions of this section.

"(b) The division or the Board shall issue a fictitious-name permit authorizing the holder thereof to use the name specified in the permit in connection with his, her, or its practice if the division or the board finds to its satisfaction that:

"(1) The applicant or applicants or shareholders of the professional corporation hold valid and current licenses as physicians and surgeons or doctors of podiatric medicine, as the case may be.

(2) The professional practice of the applicant or applicants is wholly owned and entirely controlled by the applicant or applicants.

"(3) The name under which the applicant or applicants proposes to practice is not deceptive, misleading, or confusing, and contains one of the following designations: "medical group," "medical corporation," "medical associates," "medical center," or "medical office." In the case of doctors of podiatric medicine, the same designations may be used substituting the words "podiatric medical," "podiatric surgical," "podiatry," or "podiatrists" for the word "medical," or the designations "foot clinic" or "foot and ankle clinic" may be used.

"(c) This section shall not apply to licensees who contract with, are employed by, or are on the staff of, any clinic licensed by the State Department of Health Services under Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code or any medical school approved by the division or a faculty practice plan connected with such a medical school.

"(d) Fictitious-name permits issued under this section shall be subject to Article 19 (commencing with Section 2420) pertaining to renewal of licenses, except the division shall establish procedures for the renewal of fictitious-name permits every two years on an anniversary basis. For the purpose of the conversion of existing permits to this schedule the division may fix prorated renewal fees.

"(e) The division or the board may revoke or suspend any permits issued if it finds that the holder or holders of the permit are not in compliance with the provisions of this section or any regulations adopted pursuant to this section. A proceeding to revoke or suspend a fictitious-name permit shall be conducted in accordance with Section 2230.

"(f) A fictitious-name permit issued to any license in a sole practice is automatically revoked in the event the licensee's certificate to practice medicine or podiatric medicine is revoked.

"(g) The division or the board may delegate to the executive director, or to another official of the board, its authority to review and approve applications for fictitious-name permits and to issue those permits.

"(h) The California Board of Podiatric Medicine shall administer and enforce this section as to doctors of podiatric medicine."

H. Section 2285 of the Code which provides:

"The use of any fictitious, false, or assumed name, or any name other than his or her own by a license either alone, in conjunction with a partnership or group, or as the name of a professional corporation, in any public communication, advertisement, sign, or announcement of his or her practice without a fictitious-name permit obtained pursuant to Section 2415 constitute unprofessional conduct. This section shall not apply to licensees who contract with, are employed by, ore are on the staff of, any clinic licensed by the State Department of Health Services under Chapter I (commencing with Section 1200) of Division 2 of the Health and Safety Code or any medical school approved by the division or a faculty practice plan connected with such a medical school."

I. Section 125.3 which provides, in relevant part, that the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Board a sum not to exceed the

reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE OF ACTION

(Gross Negligence)

4. Respondent Kim Beauchamp, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Business and Professions Code in that he committed acts of gross negligence in the care, treatment and management of Patient "C.A."[1/] The circumstances are as follows:

A. FACTS

(1) On October 24, 1992, at approximately 12:30 p.m. Patient C.A. went to Clinica Fememina, an abortion clinic, located at 453 S.Spring Street, Suite 1101, Los Angeles, California.

(2) Patient C.A. thought she was possibly pregnant. She was not sure because she had been having a period every month and had experienced vaginal bleeding on September 15 and 16, 1992. Further, Patient C.A. had not gained any weight. Patient C.A. explained this to the receptionist at the clinic and was told that respondent would check her.

(3) Patient C.A. was taken into an examination room where Respondent performed a bimanual vaginal examination on Patient C.A.. Respondent declared "It is small enough to do." Respondent did no further examination prior to the start of the

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1. All patient references in this pleading are by initials only. The true name of the patient shall be revealed to respondent upon his request for discovery pursuant to Government Code section 11507.6.

abortion. He did not order an ultrasound or sonogram to assist in determining the extent of Patient C.A.'s pregnancy.

(4) Respondent immediately began the abortion. Patient C.A. heard respondent talking to a female "Carmen" about personal matters. Patient C.A. was given no anesthesia or medication prior to respondent putting the suctioning instrument inside of her. Patient C.A. saw blood going into the tube.

(5) Within moments, Patient C.A. heard respondent state, "It's too big." Respondent told the nurse that he should have been told how far along Patient C.A. was. The nurse responded that she tried but respondent was busy talking.

(6) Patient C.A. heard respondent exclaim, "Oh my God, what have I done?" At this point, respondent began bumping his head against the wall.

(7) Respondent then told Patient C.A. that he had not done anything to her and that "the baby was too big for a pregnancy termination."

(8) Respondent told Patient C.A. that if she felt any pain she should take Tylenol. Patient C.A. was told to hurry up and get dressed. She had not yet tied the laces to her shoes when she was taken by the hand and pushed out of the clinic into the hall. Patient C.A.'s mother was given the $210 that Patient C.A. had paid for the abortion and was told that nothing had been done to her daughter. Patient C.A. was given a prescription for Terbutaline 2.5 mg. poq 6 #20. Patient C.A. and her mother were then escorted to the door which was immediately closed behind them.

(9) Thereafter, at approximately 1:00 p.m., C.A. accompanied her mother by car to St. George Medical Clinic to visit C.A.'s sibling there. While C.A. waited in the waiting area, she experienced extreme pain. C.A. was very weak.

(10) A doctor was summoned to check C.A. Dr. George Karroum examined C.A. and performed an ultrasound. C.A. complained of pelvic pain. C.A. told Dr. Karroum that she had gone to Clinica Femenina Para La Mujer de Hoy Grupo Medico for a pregnancy termination which was started but not completed because she was too far along. C.A. told Dr. Karroum that she was sent home with no precautions or instructions. Dr. Karroum determined that C.A. was dilated and recommended that she proceed immediately to Women's Hospital.

(11) C.A.'s mother transported her daughter to Los Angeles County Women's Hospital, located at 1240 N. Mission Road, Los Angeles 90033. She arrived at approximately 6:00 p.m.and immediately underwent an emergency cesarean section. D. Wong, M.D., delivered a baby girl. There was an intraoperative finding a 4cm. area of placental separation with post delivery of large clot placenta.

(12) The baby was in such a state that she was transferred to Daniel Freeman Hospital in Inglewood. She died two days later.

B. ACTS OF GROSS NEGLIGENCE

(1) The respondent failed to properly diagnose the patients medical condition before attempting the abortion. Specifically, respondent failed to do the following acts which

singularly and collectively represent an extreme departure from the standard of care:

(a) He failed to order tests prior to the abortion to determine the gestational age of the fetus;

(b) He failed to adequately document and failed to take any history of Patient C.A. in order to determine anything of her medical background;

(c) He failed to administer any type of anesthesia to Patient C.A. prior to the start of the abortion;

(d) He failed to perform a physical examination on Patient C.A. prior to commencement of the abortion;

(e) He failed to measure or record Patient C.A.'s vital signs;

(f) He failed to evaluate Patient C.A.'s uterus, uterine size, or contents before commencing the procedure;

(g) He failed to assess the difference in Patient C.A's uterus between an early pregnancy at 12 weeks and one which was carrying a 25-26 week fetus prior to the commencement of an abortion; and,

(h) He failed to distinguish between a 12 week size uterus or less and that of carrying a 25-26 week fetus.

(2) The respondent failed to properly treat Patient C.A. post-procedure. Specifically, he failed to do the following acts which represent an extreme departure from the standard of care:

(a) He failed to offer Patient C.A. any instructions after making a determination of premature labor;

(b) He failed to refer Patient C.A. for appropriate care;

(c) He failed to provide any follow-up service for Patient C.A., who was thought to have a pregnancy with impending premature labor;

(d) He failed to perform any physical or cardiovascular examination on Patient C.A. prior to prescribing Terbutaline, an oral tocolytic agent combined with a lack of appropriate referral;

(e) He failed to counsel Patient C.A. as to the risks and benefits of by taking the medication prescribed;

(f) He failed to arrange for proper transfer of Patient C.A once his diagnosis of premature labor was made;

(g) He failed to insure that Patient was safely escorted to proper care whether she was a victim of a failed abortion attempt or advanced premature labor;

(h) He failed to maintain adequate or appropriate medical record keeping;

(i) He documented physical findings on Patient C.A. which he himself did not elicit. Specifically, respondent wrote "HEENT" indicating that he had examined the heart and lungs of Patient C.A., even though he had not done so, and respondent wrote findings based solely on input from the patient; and,

(j) Only after the failed abortion did respondent cause to have administered a "primitive" ultrasound test for his "curiosity." These results were interpreted by an unlicensed medical assistant to show the fetal size to be 25 weeks.

SECOND CAUSE OF ACTION

(Repeated Negligent Acts)

5. Respondent is subject to disciplinary action pursuant to section 2234, subdivision (c), of the Business and Professions Code in that he committed repeated negligent acts in the care, treatment and management of Patient C.A.. Such repeated negligent acts contributed to the necessity of an emergency caesarean section delivery of a premature infant. The circumstances of this offense are more particularly alleged in paragraph 4, subparagraphs A and B, inclusive, above, and are incorporated herein by reference as though set forth fully.

THIRD CAUSE OF ACTION

(Incompetence)

6. Respondent is subject to disciplinary action pursuant to section 2234, subdivision (d), of the Business and Professions Code in that he was incompetent in his care, treatment and management of Patient C.A.. Such acts of incompetence contributed to the necessity of an emergency cesarean section. The circumstances of this offense are set forth fully in paragraph 4, subparagraphs A and B, inclusive, above, and are incorporated herein by reference as though set forth fully.

FOURTH CAUSE OF ACTION

(Permitting Another To Use License)

7. Respondent is subject to disciplinary action pursuant to section 2264 of the Business and Professions Code in that respondent permitted Carmen Moreno, an unlicensed

individual, to use his license to advertise services and to practice medicine. The circumstances of this offense are as follows:

(a) Respondent began working for Carmen Moreno in 1991. Carmen Moreno is not a licensed physician but owns abortion clinics located at 2010 Wilshire Blvd., Office 904 and 453 S. Spring Street, Suite 1101, in Los Angeles and one in Santa Ana. Respondent allowed Carmen Moreno to use his license to operate each of these clinics.

(b) While working for Carmen Moreno, abortions represented approximately 50 percent of the practice.

(c) Carmen Moreno kept all patient records. She also maintained all billing records.

(d) Carmen Moreno paid respondent a flat rate of $50 per abortion regardless of the gestational age of the fetus. Respondent performed two to four abortions per day.

(e) Respondent's practice was to perform abortions for patients 12 weeks and under. Carmen Moreno would have other doctors come in to do second trimester abortions.

(f) Respondent had no written contract with Carmen Moreno. There were no guidelines. There were no set days or hours of operation. Respondent was contacted on his beeper whenever a patient came into the office wanting an abortion. Respondent had nothing to do with hiring, personnel or quality control in the clinics.

(g) Respondent is a Medi-Cal provider who sees patients on a cash basis or who are eligible for benefits

under Medi-Cal.

FIFTH CAUSE OF ACTION

(Advertising Without Use Of Approved Fictitious Name)

16. Respondent is subject to disciplinary action for unprofessional conduct pursuant to Business and Professions Code section 2234, subdivision (e), taken in conjunction with sections 2272, 2285 and 2415, in that respondent advertised the practice of medicine under the names of "Clinica Latina Femenina," and "Clinica Latina" with addresses listed as 453 S. Spring St. Office 1101; 2010 Wilshire Blvd. Office 904, and 4111 Main St. Baldwin Park, when respondent did not have a fictitious name permit issued in the name of "Clinica Latina Femenina" or "Clinica Latina." The circumstances are as follows

(a) On or about June 1992, respondent was issued a fictitious name permit to "Clinica Femenina Para La Mujer De Hoy Grupo Medico" listed at 453 South Spring Street, suite 1101, Los Angeles, California 90013.

(b) On February 11, 1993, Medical Board of California Senior Investigators Janice Trussel and Shirley Russo went to 453 South Spring Street to personally deliver a request for records pertaining to Patient C.A.

(c) Upon entering the premises, a business card was obtained which bore the name of "Los Angeles Grupo Medico La Clinica Femenina," and under this was "Lawrence W. Scott, M.D."

(d) Inside the inner office, a copy of patient instruction sheets was obtained which bore the name of

"Albert Brown, M.D." typed across the top, with a line through it and the name of "Kim Beauchamp" printed underneath.

(e) The consent form dated October 24, 1992, signed by Patient C.A. bears the name of "Nicholas Braemer, M.D."

PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A24496, heretofore issued to respondent Kim Beauchamp, M.D.;

2. Revoking, suspending or denying Physician Assistant License Number SA20917 and approval of the respondent's authority to supervise physician's assistants, pursuant to Business and Professions Code section 3527;

3. Ordering respondent to pay the Division the actual and reasonable costs of the investigation and enforcement of this case;

4. Taking such other and further action as the Division deems proper.

DATED: AUGUST 21, 1995

Medical Board of California
Department of Consumer Affairs
State of California

Complainant

DANIEL E. LUNGREN, Attorney General
of the State of California
KAREN B. CHAPPELLE,
Deputy Attorney General
California Department of Justice
300 South Spring Street, Suite 5212
Los Angeles, California 90013-1204
Telephone: (213) 897-2578

Attorneys for Complainant

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

In the Matter of the Accusation Against: KIM BEAUCHAMP, M.D. 10150 Olivia Terrace Sun Valley, California 91352 Physician and Surgeon's Certificate No. A24496, Supervisor of Physician Assistants License No. SA20917, Respondent.	NO. 11-93-24972 OAH No. L-9510113 **FIRST AMENDED AND SUPPLEMENTAL ACCUSATION**

Complainant alleges:

PARTIES

1. Complainant, Ron Joseph, is the Executive Director of the Medical Board of California (hereinafter the "Board") and brings this accusation solely in his official capacity.

2. On or about September 17, 1971, Physician and Surgeon's Certificate No. A24496 was issued by the Board to Kim Beauchamp, M.D. (hereinafter "respondent"), and at all times

relevant to the charges brought herein, this license has been in full force and effect. Unless renewed, it will expire on October 30, 1996. Dr. Beauchamp is a supervisor of a physician assistant, having been issued his Supervisor of Physician Assistant License Number SA20917 by the Board on August 31, 1992. It has not been renewed and expired on November 30, 1995.

JURISDICTION

3. This accusation is brought before the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs (hereinafter the "Division"), under the authority of the following sections of the California Business and Professions Code (hereinafter "Code"):

A. Sections 2003 and 2004 which provide, in pertinent part, that the Division is responsible for the enforcement of the disciplinary provisions of the Medical Practices Act, for the administration and hearing of disciplinary actions, for carrying out disciplinary actions appropriate to findings made by a medical quality review committee, and revoking or otherwise limiting certificates after the conclusion of disciplinary actions.

B. Section 2220 which provides:

"Except as otherwise provided by law, the Division of Medical Quality may take action against all persons guilty of violating this chapter. The division shall enforce and administer this article as to physician and surgeon certificate holders, and the division shall

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have all the powers granted in this chapter for these purposes including, but not limited to:

"(a) Investigating complaints from the public, from other licensees, from health care facilities, or from a division of the board that a physician and surgeon may be guilty of unprofessional conduct.

"(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

"(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon."

C. Section 2227 which provides:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in section 11371 of the Government Code, or whose default has been entered, and who is found guilty may, in accordance with the provisions of this chapter.

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

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

"(3) Be placed on probation upon order of the division.

"(4) Be publicly reprimanded by the division.

"(5) Have any other action taken in relation to discipline as the division or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board."

D. Section 2234 which provides:

"The Division of Medical Quality 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, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(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."

E. Section 2264 which provides:

"The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

F. Section 2272 which provides:

"Any advertising of the practice of medicine in which the licensee fails to use his or her own name or approved fictitious name constitutes unprofessional conduct."

G. Section 2415 of the Code which provides:

"(a) Any physician and surgeon or any doctor of podiatric medicine, as the case may be, who as a sole proprietor, or in a partnership, group, or professional corporation, desires to practice under any name that would otherwise be a violation of Section 2285 may practice under that name if the proprietor, partnership, group, or corporation obtains and maintains in current status a fictitious-name permits

issued by the Division of Licensing or, in the case of doctors of podiatric medicine, the California Board of Podiatric Medicine, under the provisions of this section.

"(b) The division or the Board shall issue a fictitious-name permit authorizing the holder thereof to use the name specified in the permit in connection with his, her, or its practice if the division or the board finds to its satisfaction that:

"(1) The applicant or applicants or shareholders of the professional corporation hold valid and current licenses as physicians and surgeons or doctors of podiatric medicine, as the case may be.

(2) The professional practice of the applicant or applicants is wholly owned and entirely controlled by the applicant or applicants.

"(3) The name under which the applicant or applicants proposes to practice is not deceptive, misleading, or confusing, and contains one of the following designations: "medical group," "medical corporation," "medical associates," "medical center," or "medical office." In the case of doctors of podiatric medicine, the same designations may be used substituting the words "podiatric medical," "podiatric surgical,"

"podiatry," or "podiatrists" for the word "medical," or the designations "foot clinic" or "foot and ankle clinic" may be used.

"(c) This section shall not apply to licensees who contract with, are employed by, or are on the staff of, any clinic licensed by the State Department of Health Services under Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code or any medical school approved by the division or a faculty practice plan connected with such a medical school.

"(d) Fictitious-name permits issued under this section shall be subject to Article 19 (commencing with Section 2420) pertaining to renewal of licenses, except the division shall establish procedures for the renewal of fictitious-name permits every two years on an anniversary basis. For the purpose of the conversion of existing permits to this schedule the division may fix prorated renewal fees.

"(e) The division or the board may revoke or suspend any permits issued if it finds that the holder or holders of the permit are not in compliance with the provisions of this section or any regulations adopted pursuant to this section. A proceeding to revoke or suspend a fictitious-name permit shall be conducted in accordance with Section 2230.

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"(f) A fictitious-name permit issued to any license in a sole practice is automatically revoked in the event the licensee's certificate to practice medicine or podiatric medicine is revoked.

"(g) The division or the board may delegate to the executive director, or to another official of the board, its authority to review and approve applications for fictitious-name permits and to issue those permits.

"(h) The California Board of Podiatric Medicine shall administer and enforce this section as to doctors of podiatric medicine."

H. Section 2285 of the Code which provides:

"The use of any fictitious, false, or assumed name, or any name other than his or her own by a license either alone, in conjunction with a partnership or group, or as the name of a professional corporation, in any public communication, advertisement, sign, or announcement of his or her practice without a fictitious-name permit obtained pursuant to Section 2415 constitute unprofessional conduct. This section shall not apply to licensees who contract with, are employed by, ore are on the staff of, any clinic licensed by the State Department of Health Services under Chapter I (commencing with Section 1200) of Division 2 of the Health and Safety Code or any medical school approved by the division or a faculty practice plan connected with such a medical school."

I. Section 2261 which provides:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

J. Section 2262 which provides:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct."

K. Section 125.3 which provides, in relevant part, that the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE OF ACTION

(Gross Negligence)

4. Respondent Kim Beauchamp, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Business and Professions Code in that he committed acts of gross negligence in the care, treatment and management of Patient "C.A."[1/] The circumstances are as follows:

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1. All patient references in this pleading are by initials only. The true name of the patient shall be revealed to respondent upon his request for discovery pursuant to Government Code section 11507.6.

A. FACTS - PATIENT C.A.

(1) On October 24, 1992, at approximately 12:30 p.m., Patient C.A. went to Clinica Fememina, an abortion clinic, located at 453 S. Spring Street, Suite 1101, Los Angeles, California.

(2) Patient C.A. thought she was possibly pregnant. She was not sure because she had been having a period every month and had experienced vaginal bleeding on September 15 and 16, 1992. Further, Patient C.A. had not gained any weight. Patient C.A. explained this to the receptionist at the clinic and was told that respondent would check her.

(3) Patient C.A. was taken into an examination room where Respondent performed a bimanual vaginal examination on Patient C.A.. Respondent declared "It is small enough to do." Respondent did no further examination prior to the start of the abortion. He did not order an ultrasound or sonogram to assist in determining the extent of Patient C.A.'s pregnancy.

(4) Respondent immediately began the abortion. Patient C.A. heard respondent talking to a female "Carmen" about personal matters. Patient C.A. was given no anesthesia or medication prior to respondent putting the suctioning instrument inside of her. Patient C.A. saw blood going into the tube.

(5) Within moments, Patient C.A. heard respondent state, "It's too big." Respondent told the nurse that he should have been told how far along Patient C.A. was. The nurse responded that she tried but respondent was busy talking.

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(6) Patient C.A. heard respondent exclaim, "Oh my God, what have I done?" At this point, respondent began bumping his head against the wall.

(7) Respondent then told Patient C.A. that he had not done anything to her and that "the baby was too big for a pregnancy termination."

(8) Respondent told Patient C.A. that if she felt any pain she should take Tylenol. Patient C.A. was told to hurry up and get dressed. She had not yet tied the laces to her shoes when she was taken by the hand and pushed out of the clinic into the hall. Patient C.A.'s mother was given the $210 that Patient C.A. had paid for the abortion and was told that nothing had been done to her daughter. Patient C.A. was given a prescription for Terbutaline 2.5 mg. poq 6 #20. Patient C.A. and her mother were then escorted to the door which was immediately closed behind them.

(9) Thereafter, at approximately 1:00 p.m., C.A. accompanied her mother by car to St. George Medical Clinic to visit C.A.'s sibling there. While C.A. waited in the waiting area, she experienced extreme pain. C.A. was very weak.

(10) A doctor was summoned to check C.A. Dr. George Karroum examined C.A. and performed an ultrasound. C.A. complained of pelvic pain. C.A. told Dr. Karroum that she had gone to Clinica Femenina Para La Mujer de Hoy Grupo Medico for a pregnancy termination which was started but not completed because she was too far along. C.A. told Dr. Karroum that she was sent home with no precautions or instructions. Dr. Karroum

determined that C.A. was dilated and recommended that she proceed immediately to Women's Hospital.

(11) C.A.'s mother transported her daughter to Los Angeles County Women's Hospital, located at 1240 N. Mission Road, Los Angeles 90033. She arrived at approximately 6:00 p.m.and immediately underwent an emergency cesarean section. D. Wong, M.D., delivered a baby girl. There was an intraoperative finding a 4cm. area of placental separation with post delivery of large clot placenta.

(12) The baby was in extreme physical distress which necessitated her transfer to Daniel Freeman Hospital in Inglewood. She died two days later.

B. ACTS OF GROSS NEGLIGENCE - PATIENT C.A.

(1) The respondent failed to properly diagnose the patients medical condition before attempting the abortion. Specifically, respondent failed to do the following acts which singularly and collectively represent an extreme departure from the standard of care:

(a) He failed to order tests prior to the abortion to determine the gestational age of the fetus;

(b) He failed to adequately document and failed to take any history of Patient C.A. in order to determine anything of her medical background;

(c) He failed to administer any type of anesthesia to Patient C.A. prior to the start of the abortion;

(d) He failed to perform a physical examination on Patient C.A. prior to commencement of the abortion;

(e) He failed to measure or record Patient C.A.'s vital signs;

(f) He failed to evaluate Patient C.A.'s uterus, uterine size, or contents before commencing the procedure;

(g) He failed to assess the difference in Patient C.A's uterus between an early pregnancy at 12 weeks and one which was carrying a 25-26 week fetus prior to the commencement of an abortion; and,

(h) He failed to distinguish between a 12 week size uterus or less and that of carrying a 25-26 week fetus.

(2) The respondent failed to properly treat Patient C.A. post-procedure. Specifically, he failed to do the following acts which represent an extreme departure from the standard of care:

(a) He failed to offer Patient C.A. any instructions after making a determination of premature labor;

(b) He failed to refer Patient C.A. for appropriate care;

(c) He failed to provide any follow-up service for Patient C.A., who was thought to have a pregnancy with impending premature labor;

(d) He failed to perform any physical or cardiovascular examination on Patient C.A. prior to prescribing Terbutaline, an oral tocolytic agent combined with a lack of appropriate referral;

(e) He failed to counsel Patient C.A. as to the risks and benefits of by taking the medication prescribed;

(f) He failed to arrange for proper transfer of Patient C.A once his diagnosis of premature labor was made;

(g) He failed to insure that Patient was safely escorted to proper care whether she was a victim of a failed abortion attempt or advanced premature labor;

(h) He failed to maintain adequate or appropriate medical record keeping;

(i) He documented physical findings on Patient C.A. which he himself did not elicit. Specifically, respondent wrote "HEENT" indicating that he had examined the heart and lungs of Patient C.A., even though he had not done so, and respondent wrote findings based solely on input from the patient; and,

(j) Only after the failed abortion did respondent cause to have administered a "primitive" ultrasound test for his "curiosity." These results were interpreted by an unlicensed medical assistant to show the fetal size to be 25 weeks.

SECOND CAUSE OF ACTION

(Gross Negligence)

5. Respondent Kim Beauchamp, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Business and Professions Code in that he committed gross negligence in the care, treatment and management of Patient "G.M." The circumstances are as follows:

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A. FACTS - PATIENT G.M.

(1) In or about August 1987, Patient G.M., then 24 years of age, went for an annual gynecological check up at respondent's office, at 9140 Van Nuys Blvd., Suite 207, Panorama City, California, 91402.

(2) Patient G.M. received an examination by respondent that included a pap smear and an examination of her breasts.

(3) Patient G.M. was told by respondent that she had a small lump in her right breast the size of a grape. Prior to being told by respondent, patient G.M. had no knowledge of the lump in her right breast. At that time the lump felt "a bit hard" to patient G.M. Respondent's secretary told Patient G.M to "wait a year" to see if the lump grew any larger.

(4) Respondent advised Patient G.M. to have a mammography taken. Patient G.M. was given a written order by respondent whereupon on September 1, 1987, she proceeded to Granada Hills Community Hospital for the mammography.

(5) Respondent read the mammography results as normal.

(6) The results of the mammogram were explained to the patient by respondent's nurse, who told Patient G.M. that the lump was a small mass of dried milk.

(7) Thereafter, Patient G.M. saw respondent for further visits on June 8, 1988, for removal of an Intrauterine Device ("I.U.D."), and September 1, 1988, for vomiting due to pregnancy.

(8) Respondent continued to see Patient G.M. during her pregnancy and for postpartum care. On one occasion, Patient

G.M. complained about the lump in her right breast to respondent. Respondent told her it was "normal" because she was pregnant.

(9) After the birth of her son on March 19, 1989, the lump in her right breast had grown to the size of a baseball and was quite hard.

(10) During the period of her continued relationship with respondent, the lump in her right breast was still present and Patient G.M. could feel it. No further discussion of the lump was held between Patient G.M. and respondent in 1987 or 1988.

(11) Patient G.M. saw respondent again in 1989 and repeat mammography was ordered as well as a breast biopsy. These tests revealed that Patient G.M. had cancer that had grown to massive proportions, had spread to the left breast, and had become incurable.

(12) Patient G.M. died as a result of the breast cancer in July 1991.

B. ACTS OF GROSS NEGLIGENCE - PATIENT G.M.

(1) The respondent failed to properly diagnose the patient's medical condition in 1987 after the breast examination revealed a mass in her right breast. Specifically, respondent failed to do the following acts which, singularly and collectively, represent an extreme departure from the standard of care:

(a) He failed to order a biopsy of the right breast mass after it was detected in a routine visit in 1987;

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(b) He failed to perform and document thorough breast examinations during Patient G.M.'s office visit on June 8, 1988;

(c) He failed to properly read the mammography results;

(d) He failed to perform and document a thorough breast examination during Patient G.M.'s office visit on September 1, 1988, listing the exam on the history and physical as "normal;"

(e) He failed to perform and document a thorough breast examination on Patient G.M. on May 5, 1989;

(f) He failed to reexamine carefully the suspicious mass at regular intervals until he was certain that the mass had disappeared or that a biopsy was warranted;

(g) He removed the I.U.D. from Patient G.M. knowing that she wanted to get pregnant, without performing a breast exam or reexamination of the breast mass;

(h) He continued to see Patient G.M. during her pregnancy and failed to reexamine the right breast mass to determine whether any clinically significant changes were occurring.

THIRD CAUSE OF ACTION

(Repeated Negligent Acts)

5. Respondent is subject to disciplinary action pursuant to section 2234, subdivision (c), of the Business and Professions Code in that he committed repeated negligent acts in the care, treatment and management of Patients C.A., and G.M.

The circumstances of this offense are more particularly alleged in paragraphs 4 and 5, inclusive, above, and are incorporated herein by reference as though set forth fully.

FOURTH CAUSE OF ACTION

(Incompetence)

6. Respondent is subject to disciplinary action pursuant to section 2234, subdivision (d), of the Business and Professions Code in that he was incompetent in his care, treatment and management of PatientS C.A., and G.M. The circumstances of this offense are set forth fully in paragraphs 4 and 5, inclusive, above, and are incorporated herein by reference as though set forth fully.

FIFTH CAUSE OF ACTION

(Permitting Another To Use License)

7. Respondent is subject to disciplinary action pursuant to section 2264 of the Business and Professions Code in that respondent permitted Carmen Moreno, an unlicensed individual, to use his license to advertise services and to practice medicine. The circumstances of this offense are as follows:

(a) Respondent began working for Carmen Moreno in 1991. Carmen Moreno is not a licensed physician but owns two abortion clinics in Los Angeles and another in Santa Ana. Respondent allowed Carmen Moreno to use his license to operate each of these clinics.

(b) While working for Carmen Moreno, abortions represented approximately 50 percent of the practice.

(c) Carmen Moreno kept all patient records. She also maintained all billing records.

(d) Carmen Moreno paid respondent a flat rate of $50 per abortion regardless of the gestational age of the fetus. Respondent performed two to four abortions per day.

(e) Respondent's practice was to perform abortions for patients 12 weeks and under. Carmen Moreno would have other doctors come in to do second trimester abortions.

(f) Respondent had no written contract with Carmen Moreno. There were no guidelines. There were no set days or hours of operation. Respondent was contacted on his beeper whenever a patient came into the office wanting an abortion. Respondent had nothing to do with hiring, personnel or quality control in the clinics.

(g) Respondent is a Medi-Cal provider who sees patients on a cash basis or who are eligible for benefits under Medi-Cal.

SIXTH CAUSE OF ACTION

(Advertising Without Use Of Approved Fictitious Name)

16. Respondent is subject to disciplinary action for unprofessional conduct pursuant to Business and Professions Code section 2234, subdivision (e), taken in conjunction with sections 2272, 2285 and 2415, in that respondent advertised the practice of medicine under the names of "Clinica Latina Femenina," and "Clinica Latina" with addresses listed as 453 S. Spring St. Office 1101; 2010 Wilshire Blvd. Office 904, and 4111 Main St. Baldwin Park, when respondent did not have a fictitious name

permit issued in the name of "Clinica Latina Femenina" or "Clinica Latina." The circumstances are as follows:

(a) On or about June 1992, respondent was issued a fictitious name permit to "Clinica Femenina Para La Mujer De Hoy Grupo Medico" listed at 453 South Spring Street, suite 1101, Los Angeles, California 90013.

(b) On February 11, 1993, Medical Board of California Senior Investigators Janice Trussell and Shirley Russo went to 453 South Spring Street to personally deliver a request for records pertaining to Patient C.A.

(c) Upon entering the premises, a business card was obtained which bore the name of "Los Angeles Grupo Medico La Clinica Femenina," and under this was "Lawrence W. Scott, M.D."

(d) Inside the inner office, a copy of patient instruction sheets was obtained which bore the name of "Albert Brown, M.D." typed across the top, with a line through it and the name of "Kim Beauchamp" printed underneath.

(e) The consent form dated October 24, 1992, signed by Patient C.A. bears the name of "Nicholas Braemer, M.D."

SEVENTH CAUSE OF ACTION

(Falsification of Medical Records)

20. Respondent is subject to disciplinary action pursuant to section 2262 of the Business and Professions Code in that respondent falsified records pertaining to Patient G.M. The circumstances of this offense are as follows:

A. On April 30, 1991, respondent submitted medical records pertaining to the history and treatment of Patient G.M. Respondent then represented that these records were true and correct during his deposition taken that same day.

B. Specifically, the entry dated August 28, 1987, makes reference to "increased nodularity" in the history and notes. This entry was not and could not have been written on or about August 28, 1987, based on the date of publication of the note pad itself.

Respondent or respondent's agent altered the form to reflect the notes from an office visit on that date. The note is written on special progress sheets which bear an advertisement for a brand of medicine which bears a copyright date of 1989.

EIGHTH CAUSE OF ACTION

(Dishonesty)

21. Respondent is subject to disciplinary action for unprofessional conduct pursuant to Business and Professions Code section 2234, subdivision (e), in that respondent committed dishonest acts by knowingly representing patient medical records as being true. The circumstances of this offense are more particularly alleged in paragraph 20, subparagraphs A and B, inclusive, above, and are incorporated herein by reference as though set forth fully.

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PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A24496, heretofore issued to respondent Kim Beauchamp, M.D.;

2. Revoking, suspending or denying Physician Assistant License Number SA20917 and approval of the respondent's authority to supervise physician's assistants, pursuant to Business and Professions Code section 3527;

3. Ordering respondent to pay the Division the actual and reasonable costs of the investigation and enforcement of this case;

4. Taking such other and further action as the Division deems proper.

DATED: January 18, 1996

DANIEL E. LUNGREN, Attorney General
of the State of California

Karen Chappelle

KAREN B. CHAPPELLE
Deputy Attorney General

Attorneys for Complainant