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

11 In the Matter of the Accusation Against:	Case No. 17-97-73055
12 **ALBERT R. BROWN, M.D.**	**DEFAULT DECISION**
13 Clinica Femenina Para La Mujer 1930 Wilshire Blvd., Ste. 508 14 Los Angeles, California 90057	(Gov. Code, § 11520)
15 Physician and Surgeon's Certificate No. A 30103, 16	
Respondent. 17	

18

19 **FINDINGS OF FACT**

20 1. On September 3, 1998, Complainant Ron Joseph, in
21 his official capacity as Executive Director of the Medical Board
22 of California (the "Board"), Department of Consumer Affairs,
23 State of California filed Accusation No. 17-97-73055 against
24 Albert R. Brown, M.D. ("respondent"), before the Division of
25 Medical Quality (the "Division").
26 2. On May 3, 1976, respondent was issued Physician and
27 Surgeon's Certificate No. A 30103 by the Board. At all times

1 relevant herein, this license has been in full force and effect.
2 Unless renewed, this license will expire on July 31, 1999.
3 3. On September 3, 1998, Frederick C. Holbrook, an
4 employee of the Board, sent by certified mail a copy of
5 Accusation No. 17-97-73055, Statement to Respondent, Government
6 Code sections 11507.5, 11507.6, and 11507.7, Notice of Defense
7 forms, and a Request for Discovery, to respondent's address of
8 record with the Board which is 2010 Wilshire Boulevard, Suite
9 610, Los Angeles, California 90057, and to his address at 1930
10 Wilshire Boulevard, Suite 508, Los Angeles, California 90057. On
11 September 11, 1998 the signed domestic return receipt sent to
12 1930 Wilshire Boulevard, Suite 508 was received by the Board, and
13 on September 16, 1998 the signed domestic return receipt sent to
14 2010 Wilshire Boulevard, Suite 610 was received by the Board. A
15 copy of the Accusation, the pleading packet, Declaration of
16 Service and return receipts are attached hereto as "**Exhibit 1**"
17 and are incorporated as if fully set forth herein.
18 4. The above-described service was effective as a
19 matter of law pursuant to the provisions of Government Code
20 section 11505, subdivision (c).
21 5. Government Code section 11506 provides, in
22 pertinent part:
23 "(c) The respondent shall be entitled to a hearing
24 on the merits if the respondent files a notice of
25 defense, and the notice shall be deemed a specific
26 denial of all parts of the accusation not expressly
27 admitted. Failure to file a notice of defense shall

constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing. . . ."

6. Respondent failed to file a Notice of Defense within fifteen (15) days or at any time after service upon him of the Accusation and therefore waived his right to a hearing on the merits of Accusation No. 17-97-73055.

7. Government Code section 11520 provides, in pertinent part:

"(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent . . ."

8. Pursuant to its authority under Government Code section 11520, the Division finds that respondent is in default. The Division will take action without further hearing, and based on the respondent's admissions by way of default, finds that the allegations, and each of them, in Accusation No. 17-97-73055 are true.

DETERMINATION OF ISSUES

1. Respondent's Physician and Surgeon's Certificate is subject to disciplinary action by the Division pursuant to section 2227 of the Business and Professions Code by reason of the Findings of Fact set forth above.

2. Service of the Accusation and related documents

was proper and in accordance with the law.

3. The agency has jurisdiction to adjudicate this case by default.

4. The Division is authorized to revoke respondent's Physician's and Surgeon's Certificate based upon violations of Business and Professions Code sections 2234, subdivision (b), gross negligence; 2234, subdivision (c), repeated negligent acts; 2234, subdivision (d), incompetence; 2234, subdivision (e), dishonest acts; and 2266, failure to keep adequate records as charged in the Accusation.

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ORDER OF THE DIVISION OF MEDICAL QUALITY MEDICAL BOARD OF CALIFORNIA

Physician and Surgeon's Certificate No. A 30103 heretofore issued to respondent Albert R. Brown, M.D. is hereby revoked.

An effective date of March 22, 1999, 1999, has been assigned to this Order.

Pursuant to Government Code section 11520, subdivision (c), the respondent may serve a written motion requesting that the decision be vacated and stating the grounds relied on within seven (7) days after service of the decision on the respondent. The agency in its discretion may vacate the decision and grant a hearing on a showing of good cause, as defined in the statute.

Made this 18th day of February, 1999.

FOR THE DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
IRA LUBELL, M.D., PRESIDENT
PANEL A

DANIEL E. LUNGREN, Attorney General
of the State of California
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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Sept. 03 19 98
BY Frederick C. Holbrook ANALYST

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

In the Matter of the Accusation Against:

ALBERT R. BROWN, M.D.
Clinica Femenina Para La Mujer
1930 Wilshire Blvd., Ste. 508
Los Angeles, Ca. 90057

Physician and Surgeon's Certificate No. A30103,

Respondent.

Case No. 17-97-73055

A C C U S A T I O N

The Complainant alleges:

PARTIES

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

2. On or about May 3, 1976, Physician and Surgeon's Certificate No. A30103 was issued by the Board to ALBERT R. BROWN, M.D. (hereinafter "respondent"). At all times relevant to the charges brought herein, this license has been in full force and effect. Unless renewed, it will expire on July 31, 1999.

JURISDICTION

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

A. Section 2221.1 of the Code provides that the Board shall investigate and may take disciplinary action, including, but not limited to, revocation or suspension of licenses, against physicians and surgeons and all others licensed or regulated by the Board, who for good cause, knowingly fail to protect patients by failing to follow infection control guidelines of the Board, thereby risking transmission of blood-borne infectious diseases from the physician and surgeon or other health care provider regulated by the applicable board.

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

C. Section 2234 of the Code provides that 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."

D. Section 2266 of the Code provides:

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

COST RECOVERY

E. Section 125.3 of the Code provides that in any order issued in resolution of a disciplinary proceeding before any board within the department, the board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement, including the Attorney General costs, of the case.

HEALTH AND SAFETY CODE

4. Section 7054 of the Health and Safety Code provides:

"(a) Except as authorized pursuant to the sections

1 referred to in subdivision (b), every person who deposits
2 or disposes of any human remains in any place, except in
3 a cemetery, is guilty of a misdemeanor.

4 "(b) Cremated remains may be disposed of pursuant to
5 Section 7117 and 103060 or Section 7054.6 and 103060.

6 "(c) . . . ."

7 5. Section 7054.3 of the Health and Safety Code
8 provides:

9 "Notwithstanding any other provision of law, a
10 recognizable dead human fetus of less than 20 weeks
11 uterogestation not disposed of by interment shall be
12 disposed of by incineration."

13 6. Section 117690 of the Health and Safety Code, in
14 relevant part, provides:

15 "(a) 'Medical waste' means waste that meets both of
16 the following requirements:

17 "(1) The waste is composed of waste that is
18 generated or produced as a result of any of the following
19 actions:

20 "(A) Diagnosis, treatment, or immunization of human
21 beings or animals.

22 ". . .

23 "(2) The waste is either of the following:

24 "(A) Biohazardous waste.

25 "(B) Sharps waste.

26 ". . . ."

27 / / /

7. Section 117705 of the Health and Safety Code, in relevant part, provides:

"'Medical waste generator' means any person whose act or process produces medical waste and includes, but is not limited to, a provider of health care, as defined in subdivision (d) of Section 56.05 of the Civil Code. All of the following are examples of businesses that generate medical waste:

"(a) Medical and dental offices,clinics, hospitals, surgery centers, laboratories, research laboratories, unlicensed health facilities, those facilities required to be licensed pursuant to Division 2 (commencing with Section 1200), chronic dialysis clinics, as registered pursuant to Division 2 (commencing with Section 1200), and education research facilities.

". . . ."

8. Section 117750 of the Health and Safety Code provides:

"'Sharps container' means a rigid puncture-resistant container that, when sealed, is leak resistant and cannot be reopened without great difficulty."

9. Section 117755 of the Health and Safety Code provides:

"'Sharps waste' means any device having acute rigid corners, edges, or protuberances capable of cutting or piercing, including, but not limited to, all of the following:

"(a) Hypodermic needles, hypodermic needles with syringes, blades, needles with attached tubing, syringes contaminated with biohazardous waste, acupuncture needles, and root canal files.

"(b) Broken glass items, such as Pasteur pipettes and blood vials contaminated with biohazardous waste."

"(c) Any item capable of cutting or piercing that is contaminated with trauma scene waste."

10. Section 117760 of the Health and Safety Code provides:

"'Small quantity generator' means a medical waste generator that generates less than 200 pounds per month of medical waste."

11. Section 117945 of the Health and Safety Code provides:

"Small quantity generators who are not required to register pursuant to this chapter shall maintain on file in their office all of the following:

"(a) An information document stating how the generator contains, stores, treats, and disposes of any medical waste generated through any act or process of the generator.

"(b) Records of any medical waste transported offsite for treatment and disposal, including the quantity of waste transported, the date transported, and the name of the registered hazardous waste hauler or individual hauling the waste pursuant to Section 118030.

The small quantity generator shall maintain these records for not more than two years.

12. Section 117950 of the Health and Safety Code, in relevant part, provides:

"(a) Each large quantity generator, except as specified in subdivisions (b) and (c), shall register with the enforcement agency. Large quantity generators owning or operating a medical waste treatment facility shall also apply for a permit for that treatment facility pursuant to Chapter 7 (commencing with Section 118130).

". . . ."

13. Section 117955 of the Health and Safety Code, in relevant part, provides:

"Large quantity generators subject to Section 117950 shall register with the enforcement agency . . . ."

14. Section 117960 of the Health and Safety Code provides:

"Any large quantity generator required to register with the enforcement agency pursuant to Section 117950 shall file with the enforcement agency a medical waste management plan, on forms prescribed by the enforcement agency containing, but not limited to, all of the following:

"(a) The name of the person.

"(b) The business address of the person.

"(c) The type of business.

"(d) The types, and the estimated average monthly

quantity, of medical waste generated.

"(e) The type of treatment used onsite, if applicable. For generators with onsite medical waste treatment facilities, including incinerators or steam sterilizers or other treatment facilities as determined by the enforcement agency, the treatment capacity of the onsite treatment facility.

"(f) The name and business address of the registered hazardous waste hauler used by the generator to have untreated medical waste removed for treatment, if applicable.

"(g) The name and business address of the registered hazardous waste hauler service provided by the building management to which the building tenants may subscribe or are required to subscribe by the building management, if applicable.

"(h) The name and business address of the offsite medical waste treatment facility to which the medical waste is being hauled, if applicable.

"(i) An emergency action plan complying with regulations adopted by the department.

"(j) A statement certifying that the information provided is complete and accurate."

15. Section 118215 of the Health and Safety Code, in relevant part, provides:

"A person generating or treating medical waste shall ensure that the medical waste is treated by one of the

following methods, thereby rendering it solid waste, as defined in Section 40191 of the Public Resources Code, prior to disposal:

"(a)(1) Incineration at a permitted medical waste treatment facility . . . ."

16. Section 118220 of the Health and Safety Code provides:

"Recognizable human anatomical parts, with the exception of teeth not deemed infectious by the attending physician and surgeon or dentist, shall be disposed of by interment or in accordance with subdivision (a) of Section 118215, unless otherwise hazardous."

17. Section 118025 of the Health and Safety Code provides:

"All medical waste shall be hauled by either a registered hazardous waste hauler or by a person with an approved limited-quantity exemption granted pursuant to Section 118030."

18. Section 118285 of the Health and Safety Code provides:

"To containerize sharps waste, a person shall do all of the following;

"(a) Place all sharps waste into a sharps container.

"(b) Tape closed or tightly lid full sharps containers ready for disposal to preclude loss of contents.

"(c) Store sharps containers ready for disposal for

1 not more than seven days without the written approval of
2 the enforcement agency.

3 "(d) Label sharps containers with the words 'sharps
4 waste' or with the international biohazard symbol and the
5 word 'BIOHAZARD'."

6 19. Section 128275 of the Health and Safety Code
7 provides:

8 "To containerize or store medical waste, a person
9 shall do all of the following:

10 "(a) Medical waste shall be contained separately
11 from other waste at the point of origin in the producing
12 facility. Sharps containers may be placed in biohazard
13 bags or in containers with biohazard bags.

14 "(b) . . .

15 "(c) Sharps waste shall be contained in a sharps
16 container pursuant to Section 118285.

17 ". . . ."

18 20. Section 123445 of the Health and Safety Code
19 provides:

20 "(a) Except as provided in subdivision (b), at the
21 conclusion of any scientific or laboratory research or
22 any other kind of experimentation or study upon fetal
23 remains, the fetal remains shall be promptly interred or
24 disposed of by incineration.

25 "Storage of the fetal remains prior to the
26 completion of the research, experimentation, or study
27 shall be in a place not open to the public, and the

method of storage shall prevent any deterioration of the fetal remains that would create a health hazard.

"(b) Subdivision (a) shall not apply to public or private educational institutions.

"Any violation of this section is a misdemeanor."

BUDGET ACT PROVISION

21. Section 16.01 of the 1997/1998 Budget Act of the State of California in pertinent part provides:

"(a) No funds appropriated by this act may be expended to pay any Medi-Cal claim for any service performed by a physician while that physician's license is under suspension or revocation due to a disciplinary action of the Medical Board of California.

"(b) No funds appropriated by this act may be expended to pay any Medi-Cal claim for any surgical service or other invasive procedure performed on any Medi-Cal beneficiary by a physician if that physician has been placed on probation due to a disciplinary action of the Medical Board of California related to the performance of that specific service or procedure on any patient, except in any case where the board makes a determination during its disciplinary process that there exist compelling circumstances that warrant continued Medi-Cal reimbursement during the probationary period."

FIRST CAUSE FOR DISCIPLINE

(Dishonest or Corrupt Acts)

22. Respondent ALBERT R. BROWN, M.D. is subject to

1 disciplinary action under section 2234, subdivision (e), of the
2 Business and Professions Code for dishonest or corrupt acts in that
3 respondent improperly and illegally disposed of medical waste,
4 including fetal remains, in violation of the Medical Waste
5 Management Act. The circumstances are as follows:

6 A. On or about and during March 1997, respondent
7 was the owner and operator of the Clinica Femenina Para La
8 Mujer, also known as the West Coast Medical Center, located at
9 1930 Wilshire Boulevard, Suite 508, Los Angeles, California
10 90057. Abortions, among other procedures, were performed at
11 respondent's clinic. Respondent personally performed each
12 abortion.

13 B. On or about and during March 1997, Dennis
14 Figueroa, an employee of Bethel Printing, a printing service
15 which respondent utilized to print advertisements and
16 handbills for the clinic, was asked by Vilma, respondent's
17 medical office manager, to dispose of five sealed, cardboard
18 boxes for the clinic. Figueroa, at Vilma's request, earlier
19 had provided Clinica Femenina Para La Mujer with several large
20 empty cardboard boxes. Figueroa recognized that the boxes,
21 now sealed, were among those he had provided to the clinic.
22 Figueroa was advised not to open the boxes, not to let anyone
23 see him dispose of the boxes, and to discard the boxes in such
24 a way that they would not be discovered. Figueroa agreed to
25 dispose of the boxes, as instructed. Figueroa was given Fifty
26 Dollars ($50.00), in cash, for each box. Figueroa used a
27 dolly to transport the boxes from the clinic to his vehicle.

Each box weighed approximately 20 pounds.

C. On or about during March 1997, Figueroa drove to Chino Hills, California, and left the five cardboard boxes along California Highway 71 near California Highway 60. Figueroa made no effort to hide the boxes once he discarded them from his vehicle and, with a day or two, the boxes were found and opened. The discovery was publicly reported by various television and news media. Figueroa was contacted by respondent's employee and told that respondent was very angry that the boxes had not been disposed of in such a way that they would not be discovered. Figueroa was also told that respondent would not employ his services again.

D. Collectively, the five boxes contained the remains of approximately 54 fetuses with varying uterogestational ages. There were seven males, eight females, and 39 of undetermined gender. The San Bernardino Sheriff's Department launched an investigation into the origin of the fetuses and, in so doing, traced the medical waste to the Clinica Femenina Para La Mujer.

E. Prior to March 1997, respondent had been utilizing Laboratory Corporation of America (formerly National Health Laboratories) to transport the medical waste from Clinica Femenina Para La Mujer for treatment and disposal. Laboratory Corporation of America, however, would not dispose of fetuses of second trimester uterogestational age or greater.

F. On or about March 25, 1997, an inspection of

respondent's Clinica Femenina Para La Mujer revealed the following:

(1) The door to the room in which the medical waste generated by the facility was stored was unlocked; there were no warning signs posted on the medical waste storage room door indicating the presence of biohazardous materials and informing unauthorized personnel to keep out, in violation of Health and Safety Code section 118310.

(2) Sharps waste was not sealed inside the sharps container, in violation of Health and Safety Code section 118285.

(3) Using an unlicensed transporter of medical waste--namely, Laboratory Corporation of America and Dennis Figueroa--to haul the clinic's waste, in violation of Health and Safety Code section 118025.

(4) Not having any documentation for the medical waste transported for treatment and disposal, in violation of Health and Safety Code sections 117945 and 117950.

(5) Not having and not having prepared a medical waste management plan, in violation of Health and Safety Code sections 117945 and 117960.

(6) Not having registered as a medical waste generator, in violation of Health and Safety Code sections 117924 and 117955.

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SECOND CAUSE FOR DISCIPLINE

(Gross Negligence--Patient M.C.[1])

23. Respondent ALBERT R. BROWN, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Business and Professions Code in that respondent was grossly negligent during his care, treatment and management of patient M.C. The circumstances are as follows:

A. On or about April 17, 1996, respondent performed an elective therapeutic abortion on M.C., at the patient's request. Patient M.C. was then 19 years old, according the patient's medical record prepared and maintained by respondent. The patient's family and medical history was taken the preceding day. Respondent did not physically examine the patient prior to performing the abortion procedure. Respondent did not determine the uterogestational age of the fetus or did not record the fetus' uterogestational age in the patient's records.

B. On or about August 17, 1996, respondent performed an elective therapeutic abortion on M.C., at the patient's request. Patient M.C. was then 19 years old, according the patient's medical record prepared and maintained by respondent. The patient's family and medical history was taken. Respondent did not physically examine the patient prior to performing the abortion procedure. Respondent did

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1. All patient references in this pleading shall be by initials only. The true name(s) of the patient(s) are known to respondent and will be disclosed to him upon his timely written request for discovery pursuant to Government Code section 11507.6.

not determine the uterogestational age of the fetus or did not record the fetus' uterogestational age in the patient's records.

C. On or about February 11, 1997, respondent performed an elective therapeutic abortion on M.C., at the patient's request. Patient M.C. was then 20 years old, according the patient's medical record prepared and maintained by respondent. The patient's family and medical history was taken . Respondent did not physically examine the patient prior to performing the abortion procedure. Respondent did not determine the uterogestational age of the fetus or did not record the fetus' uterogestational age in the patient's records. Respondent did not prepare an operative report describing the procedure performed.

D. A section of the fetal remains was sent to the Diamond Reference Laboratory. The pathology report therefor, dated February 19, 1997, did not show any tissue pertaining to the pregnancy. Respondent did no follow up to determine why.

E. The fetal remains of the abortion procedure performed on or about February 11, 1996, were placed in a plastic container and then, after having been kept in respondent's office for approximately one month, packed in cardboard boxes with the remains of 53 other fetuses, and discarded along a public thoroughfare.

F. The following acts and omissions of respondent during his care, treatment and management of patient M.C., individually and collectively, constituted extreme departures

from the standard of care:

(1) Failing to examine the patient physically prior to scheduling the patient for an abortion procedure on April 17, 1996, August 17, 1996, and February 11, 1997;

(2) Failing to determine the gestational age of the fetus, or failing to record the manner in which the gestational age was determined, in the patient's medical records prior to performing abortions on April 17, 1996, August 17, 1996, and February 11, 1997;

(3) Failing to prepare an operative report describing the abortion procedure performed on or about February 11, 1997; and,

(4) Failing to dispose of the fetal remains from the abortion procedure performed on or about February 11, 1997, in a proper and lawful manner.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence--Patient N.S.)

24. Respondent ALBERT R. BROWN, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Business and Professions Code in that respondent was grossly negligent during his care, treatment and management of patient N.S. The circumstances are as follows:

A. On or about September 12, 1996, respondent performed an elective therapeutic abortion on N.S., at the

patient's request. Patient N.S. was then 22 years old, according the patient's medical record prepared and maintained by respondent. The patient's family and medical history was taken the preceding day. Respondent did not physically examine the patient prior to performing the abortion procedure. Respondent recorded the fetus' uterogestational age as "24 weeks" but did not record in the patient's records the manner in which the age of the fetus was measured.

B. The fetal remains of the abortion procedure performed on or about September 12, 1996, were placed in a plastic container and then, after having been kept in respondent's office for approximately six months, packed in cardboard boxes with the remains of 53 other fetuses, and discarded along a public thoroughfare.

C. The following acts and omissions of respondent during his care, treatment and management of patient N.S., individually and collectively, constituted extreme departures from the standard of care:

(1) Failing to examine the patient physically prior to scheduling the patient for an abortion procedure;

(2) Failing to determine the gestational age of the fetus or failing to record the manner in which the gestational age was determined in the patient's medical records; and,

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(3) Failing to dispose of the fetal remains in a proper and lawful manner.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence--Patient A.M.)

25. Respondent ALBERT R. BROWN, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Business and Professions Code in that respondent was grossly negligent during his care, treatment and management of patient A.M. The circumstances are as follows:

A. On or about June 29, 1996, respondent performed an elective therapeutic abortion on W.A., at the patient's request. Respondent did not physically examine the patient. Respondent recorded the fetus' uterogestational age as "23 weeks" but did not record in the patient's records the manner in which the age of the fetus was measured.

B. Respondent prepared a post operative report on behalf of patient A.M. but did not date the report.

C. On or about July 8, 1996, patient A.M. was seen by respondent for a follow up examination. Although respondent noted the possibility of endometritis, respondent did not follow this diagnosis and assessment.

D. On or about January 21, 1997, respondent performed another elective therapeutic abortion on A.M. No history was taken for the patient. Respondent did not physically examine the patient. Respondent recorded the

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fetus' uterogestational age as "20 weeks" but again did not record in the patient's records the manner in which the age of the fetus was measured.

E. An examination of the fetal remains from the abortion performed on or about January 21, 1997, showed that the uterogestational age of the fetus was 25, not 20, weeks.

F. Included in patient A.M's medical records are three undated and unidentified ultrasounds.

G. Patient A.M. signed a surgery consent form prior to each therapeutic abortion. Neither consent form identified the surgical procedure to be performed.

H. The fetal remains of the abortion procedure performed on or about January 21, 1997, were placed in a plastic container and then, after having been kept in respondent's office for approximately two months, packed in cardboard boxes with the remains of 53 other fetuses, and discarded along a public thoroughfare.

I. The following acts and omissions of respondent during his care, treatment and management of patient A.M., individually and collectively, constituted extreme departures from the standard of care:

(1) Failing to examine the patient physically prior to scheduling the patient for an abortion procedure;

(2) Failing to record the patient's name on the ultrasounds and to record the date the ultrasounds were taken;

(3) Failing to determine the gestational age of the fetus or failing to record the manner in which the gestational age was determined in the patient's medical records;

(4) Failing to follow up on the diagnosis of endometritis;

(5) Failing to date the post-operative report;

(6) Failing to name the surgical procedure to be performed in the surgery consent form; and,

(7) Failing to dispose of the fetal remains in a proper and lawful manner.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence--Patient S.A.)

26. Respondent ALBERT R. BROWN, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Business and Professions Code in that respondent was grossly negligent during his care, treatment and management of patient S.A. The circumstances are as follows:

A. On or about September 20, 1996, respondent performed an elective therapeutic abortion on S.A., at the patient's request. Patient S.A. was then 28 years old, according the patient's medical record prepared and maintained by respondent. The patient's family and medical history was taken the preceding day. Respondent did not physically examine the patient prior to performing the abortion

procedure. Respondent recorded the fetus' uterogestational age as "23 weeks" but did not record in the patient's records the manner in which the age of the fetus was measured.

B. Included in patient S.A.'s medical records prepared and maintained by respondent are three ultrasounds. None of the ultrasounds are dated. None of the ultrasounds have a name or other indicia of identification printed on it.

C. The fetal remains of the abortion procedure performed on or about September 20, 1996, were placed in a plastic container and then, after having been kept in respondent's office for approximately six months, packed in cardboard boxes with the remains of 53 other fetuses, and discarded along a public thoroughfare.

D. The following acts and omissions of respondent during his care, treatment and management of patient S.A., individually and collectively, constituted extreme departures from the standard of care:

(1) Failing to examine the patient physically prior to scheduling the patient for an abortion procedure;

(2) Failing to record the patient's name on the ultrasound and to record the date the ultrasound was taken;

(3) Failing to determine the gestational age of the fetus or failing to record the manner in which the gestational age was determined in the patient's medical records; and,

(4) Failing to dispose of the fetal remains in a proper and lawful manner.

SIXTH CAUSE FOR DISCIPLINE

(Gross Negligence--Patient W.A.)

27. Respondent ALBERT R. BROWN, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Business and Professions Code in that respondent was grossly negligent during his care, treatment and management of patient W.A. The circumstances are as follows:

A. On or about June 8, 1996, respondent performed an elective therapeutic abortion on W.A., at the patient's request. Patient W.A. was then 15 years, 11 months old. The patient's family and medical history was not taken. Respondent did not physically examine the patient. Respondent recorded the fetus' uterogestational age as "24 weeks" but did not record in the patient's records the manner in which the age of the fetus was measured.

B. On or about January 8, 1997, respondent performed another elective therapeutic abortion on W.A., who was then 16 years, six months old. No history was taken for the patient. Respondent did not physically examine the patient. Respondent again recorded the fetus' uterogestational age as "24 weeks" but again did not record in the patient's records the manner in which the age of the fetus was measured.

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C. Included in patient W.A.'s medical records were two ultrasounds. One has patient W.A.'s name printed on it and is dated June 5, 1996. The other has no name or date.

D. The fetal remains of the abortion procedure performed on or about January 8, 1997, were placed in a plastic container and then, after having been kept in respondent's office for approximately two months, packed in cardboard boxes with the remains of 53 other fetuses, and discarded along a public thoroughfare.

E. The following acts and omissions of respondent during his care, treatment and management of patient W.A., individually and collectively, constituted extreme departures from the standard of care:

(1) Failing to take an adequate history or to examine the patient physically prior to scheduling the patient for an abortion procedure;

(2) Failing to record the patient's name on the ultrasound and to record the date the ultrasound was taken;

(3) Failing to determine the uterogestational age of the fetus or failing to record the manner in which the gestational age was determined in the patient's medical records; and,

(4) Failing to dispose of the fetal remains in a proper and lawful manner.

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SEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence--Patient E.V.)

28. Respondent ALBERT R. BROWN, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Business and Professions Code in that respondent was grossly negligent during his care, treatment and management of patient E.V. The circumstances are as follows:

A. On or about September 1, 1996, respondent performed an elective therapeutic abortion on E.V., at the patient's request. Patient E.V. was then 16 years, 11 months old, according the patient's medical record prepared and maintained by respondent. The patient's family and medical history was taken on August 30, 1996. Respondent did not physically examine the patient prior to performing the abortion procedure. Respondent recorded the fetus' uterogestational age as "22-24 weeks" but did not record in the patient's records the manner in which the age of the fetus was measured.

B. Included in patient E.V.'s medical records prepared and maintained by respondent are three ultrasounds. None of the ultrasounds are dated. None of the ultrasounds have a name or other indicia of identification printed on it.

C. Patient E.V. completed a consent for surgery form but did not indicate whether or not she wanted to seek a second medical opinion.

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D. During the abortion procedure, pain medication was administered to patient E.V. intravenously without monitoring.

E. Complications arose during the abortion procedure including, but not limited to, possible perforation of the uterine wall. Patient E.V. was scheduled for a follow up visit on September 3, 1996. Although patient E.V. presented herself for the follow up visit, as scheduled, respondent did not perform a pelvic examination.

F. Laboratory results of tests performed on patient E.V. showed an elevated white blood cell count, on September 4, 1996, and elevated liver function, on September 11, 1996. Respondent did not assess or follow the patient's elevated white blood cell count or liver function.

G. The fetal remains of the abortion procedure performed on or about September 1, 1996, were placed in a plastic container and then, after having been kept in respondent's office for approximately six months, packed in cardboard boxes with the remains of 53 other fetuses, and discarded along a public thoroughfare.

H. An examination of the fetal remains from the abortion performed on or about September 1, 1996, revealed that the uterogestational age of the fetus was 26, not 22-24, weeks.

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I. The following acts and omissions of respondent during his care, treatment and management of patient E.V., individually and collectively, constituted extreme departures from the standard of care:

(1) Failing to examine the patient physically prior to scheduling the patient for an abortion procedure;

(2) Failing to record the patient's name on the ultrasound and to record the date the ultrasound was taken;

(3) Failing to determine the uterogestational age of the fetus or failing to record the manner in which the gestational age was determined in the patient's medical records;

(4) Administering medication intravenously without monitoring;

(5) Failing to perform a pelvic examination during the follow up visit where perforation of the uterine wall is suspected;

(6) Failing to assess or follow the patient's elevated white blood cell count or liver function; and,

(7) Failing to dispose of the fetal remains in a proper and lawful manner.

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EIGHTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

29. Respondent ALBERT R. BROWN, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code in that respondent committed repeated negligent acts during his care, treatment and management of patients M.C., N.S., A.M., S.A., W.A., and E.V. The circumstances are as follows:

A. Complainant refers to and, by this reference, incorporates herein the allegations set forth in paragraphs 23 through 28, inclusive, above, as though fully set forth.

NINTH CAUSE FOR DISCIPLINE

(Incompetence)

30. Respondent ALBERT R. BROWN, M.D. is subject to disciplinary action under section 2234, subdivision (d), of the Code in that respondent demonstrated a lack of knowledge or ability to discharge his professional medical obligations during his care, treatment and management of patients M.C., N.S., A.M., S.A., W.A., and E.V. The circumstances are as follows:

A. Complainant refers to and, by this reference, incorporates herein the allegations set forth in paragraphs 23 through 28, inclusive, above, as though fully set forth.

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TENTH CAUSE FOR DISCIPLINE

(Failure To Keep Adequate Records)

31. Respondent ALBERT R. BROWN, M.D. is subject to disciplinary action under section 2266 of the Code in that respondent failed to keep adequate or accurate medical records for patients M.C., N.S., A.M., S.A., W.A., and E.V., relating to the provision of his services. The circumstances are as follows:

A. Complainant refers to and, by this reference, incorporates herein the allegations set forth in paragraphs 23 through 28, inclusive, above, as though fully set forth.

ELEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

32. Respondent ALBERT R. BROWN, M.D. is subject to disciplinary action for unprofessional conduct, generally, under section 2234 of the Code, as follows:

A. Complainant refers to and, by this reference, incorporates herein the allegations set forth in paragraphs 22 through 28, inclusive, above, as though fully set forth.

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 and Surgeon's Certificate Number A30103, heretofore issued to respondent ALBERT R. BROWN, M.D.;

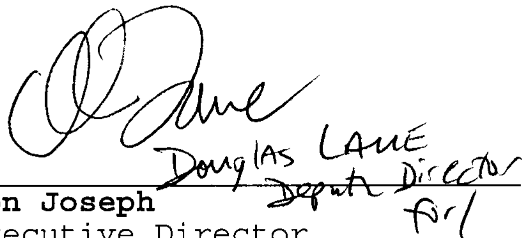
2. Revoking, suspending or denying approval of respondent's authority to supervise physician's assistants,

pursuant to section 3527 of the Code;

3. Ordering respondent to pay the Division the reasonable costs of the investigation and enforcement of this case and, if placed on probation, the costs of probation monitoring; and,

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

DATED: September 03, 1998.



Ron Joseph
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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