

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

In the Matter of the Accusation )  
Against: )

SURESH GANDOTRA, M.D. )  
Certificate No. A-29677 )

Respondent. )

No. 06-90-1180 )

DECISION

The attached Stipulated Decision in case number  
06-90-1180 is hereby adopted by the Division of Medical Quality of  
the Medical Board of California as its decision in the above  
entitled matter.

This Decision shall become effective on January 20, 1995.

IT IS SO ORDERED January 20, 1995.

DIVISION OF MEDICAL QUALTY  
MEDICAL BOARD OF CALIFORNIA

By

*Ira Lubell M.D.*

IRA LUBELL, M.D.  
Chairperson

1 DANIEL E. LUNGREN, Attorney General  
 of the State of California  
 2 MARGARET A. LAFKO  
 Deputy Attorney General, State Bar No. 105921  
 3 Department of Justice  
 110 West A Street, Suite 1100  
 4 P.O. Box 85266  
 San Diego, California 92186-5266  
 5 Telephone: (619) 645-2064  
 6 Attorneys for Medical Board of California

7  
 8 BEFORE THE  
 9 DIVISION OF MEDICAL QUALITY  
 MEDICAL BOARD OF CALIFORNIA  
 10 DEPARTMENT OF CONSUMER AFFAIRS

11	In the Matter of the Accusation and Surrender of Licensure of:	)	Accusation No. D5389 OAH No. 07-91-12088
12	SURESH GANDOTRA, M.D.	)	STIPULATION FOR
13	DOB: [REDACTED]	)	SURRENDER OF
14	215 S. Owens Drive Anaheim, CA 92807	)	CERTIFICATE, PERMIT, DECISION AND ORDER
15	Physician's and Surgeon's Certificate No. A29677	)	
16	Fictitious Name Permit	)	
17	El Norte Clinica Medica 342 San Ysidro Blvd. San Ysidro, CA 92173	)	
18	Permit No. FNP 18167,	)	
19	Respondent.	)	

RECEIVED  
 DEC 21 1994  
 Rec'd.....

21 IT IS HEREBY STIPULATED by and between the parties in  
 22 the above-entitled matter as follows:  
 23 1. Complainant Dixon Arnett is the Executive Director  
 24 of the Medical Board of California, Department of Consumer  
 25 Affairs, State of California ("Board") and is represented herein  
 26 by Daniel E. Lungren, Attorney General of the State of  
 27 California, by Margaret A. Lafko, Deputy Attorney General.  
 28 ///

1.

1                   2.    Suresh Gandotra, M.D. ("respondent") is  
2 represented by Evan Ginsburg, Esq., 440 E. Commonwealth, Suite  
3 100, Fullerton, California 92632; telephone (714) 680-3636; fax  
4 no. (714) 680-3315.

5                   3.    At all times mentioned herein, respondent was  
6 licensed by the Board under Physician's and Surgeon's Certificate  
7 No. A29677. Said Certificate was issued by the Board on  
8 September 10, 1975, and would expire on April 30, 1995.  
9 Respondent has no record of prior discipline and is not a  
10 supervisor of a Physician Assistant.

11                   4.    On April 29, 1991, the Board issued Fictitious  
12 Name Permit No. FNP 18167 to respondent for the name of El Norte  
13 Clinica Medica, located at 342 West San Ysidro Blvd., San Ysidro,  
14 California 92173. Said permit will expire on April 30, 1995.

15                   5.    On September 23, 1993, an Accusation was filed  
16 against respondent's certificate regarding a felony conviction on  
17 May 2, 1990. (See Exh. 1.) This Accusation is pending.

18                   6.    On December 16, 1994, an Ex-Parte TRO Petition was  
19 filed in the San Diego Superior Court in Case No. SB003494 and a  
20 TRO Order was granted restraining respondent and his clinic, El  
21 Norte Clinica Medica, from practicing medicine. (See Exh. 2.)  
22 This action was based on respondent's criminal conviction and  
23 allegations of gross negligence in performing two abortions.

24                   7.    Respondent has carefully read and fully  
25 understands the contents, force, and effect of this Stipulation  
26 for Surrender of Certificate and Permit.

27                   8.    Respondent is desirous of surrendering his  
28 certificate and permit.

2.

1           9. Respondent is fully aware of his right to a full  
 2 hearing on the pending Accusation and on supplemental allegations  
 3 which would be filed regarding patients A.L.G. and M.O.R. (See  
 4 Exh. 2.), his right to present witnesses and evidence on his own  
 5 behalf, his right to cross-examine all witnesses testifying  
 6 against him, his right to reconsideration, judicial review,  
 7 appeal, and all other rights which may be accorded him pursuant  
 8 to the California Administrative Procedure Act and the California  
 9 Code of Civil Procedure.

10           10. Respondent admits that he has been convicted of a  
 11 crime which constitutes a basis for discipline pursuant to  
 12 Business and Professions Code section 2236 as alleged in the  
 13 pending Accusation. (Exh. 1.)

14           11. Respondent admits that he was grossly negligent in  
 15 treating patient A.L.G. named in the TRO Petition. (Exh. 2.)

16           12. Respondent understands that in signing this  
 17 Stipulation for Surrender of Certificate, he is enabling the  
 18 Division of Medical Quality, Medical Board of California, State  
 19 of California, to issue its order accepting his surrender of his  
 20 California Physician's and Surgeon's Certificate No. A29677  
 21 without any further notice, opportunity to be heard, or formal  
 22 proceeding.

23           13. Should respondent ever seek reinstatement of his  
 24 surrendered certificate, *in addition to the admissions in paragraphs 10 and 11 above,* he admits only for the purpose of a  
 25 reinstatement hearing that his treatment of patient M.O.R.  
 26 constituted gross negligence.

27           14. Respondent hereby surrenders his California  
 28 Physician's and Surgeon's Certificate No. A29677 to the Division

*eg.*

1 of Medical Quality, Medical Board of California, State of  
2 California, for its formal acceptance.

3 15. Upon formal acceptance of respondent's surrender  
4 of certificate by the Division of Medical Quality, Medical Board  
5 of California, State of California, respondent further agrees to  
6 physically surrender, and cause to be delivered to the Board,  
7 both his California Physician's and Surgeon's wall Certificate  
8 No. A29677 and wallet certification, as well as permit FNP-  
9 18167.

10 16. Respondent fully understands that upon formal  
11 acceptance of his Surrender of Certificate and Permit by the  
12 Division of Medical Quality, Medical Board of California, State  
13 of California, he will no longer be permitted to practice as a  
14 physician and surgeon in the State of California, nor permitted  
15 to have any financial interest or control in El Norte Clinica  
16 Medica.

17 17. This Stipulation for Surrender of Certificate and  
18 Permit is intended by the parties herein to be an integrated  
19 writing representing the complete, final, and exclusive  
20 embodiment of the agreements of the parties.

21 18. This Stipulation for Surrender of Certification  
22 and Permit shall be subject to the approval of the Division of  
23 Medical Quality, Medical Board of California, State of  
24 California. If the Division fails, for any reason, to approve

25 ///

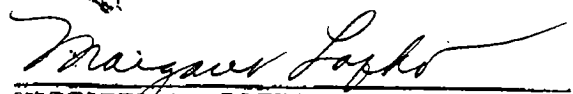
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27 ///

28 ///

1 this Stipulation, it shall be of no force and effect for either  
2 party.

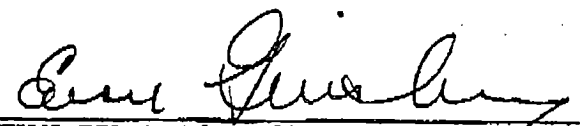
3  
4 DATED: December 23, 1994

5  
6 

7 MARGARET A. LAFKO  
8 Deputy Attorney General

9 Attorney for Medical Board  
10 of California

11 DATED: 12-23-94

12  
13 

14 EVAN GINSBURG, ESQ.

15 Attorney for Respondent  
16  
17  
18  
19  
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1 ACKNOWLEDGEMENT

2 I, SURESH GANDOTRA, M.D., have read the above  
3 Stipulation and enter into it freely, voluntarily, intelligently  
4 and with full knowledge of its force and effect. I hereby  
5 surrender my California Physician's and Surgeon's Certificate No.  
6 A29677 and permit FNP 18167 to the Division of Medical Quality,  
7 Medical Board of California, State of California, for its formal  
8 acceptance. I fully understand that, upon formal acceptance of  
9 my surrender of California Physician's and Surgeon's Certificate  
10 No. A29677 and permit FNP 18167 by the Division, I will lose all  
11 rights and privileges to practice as a physician and surgeon in  
12 the State of California.

13 DATED: 12-22-94

14  
15   
16 SURESH GANDOTRA, M.D.

17 DECISION AND ORDER

18 Pursuant to its authority under California Business and  
19 Professions Code sections 2220, 2227, 2234, 2236, and 2285 and  
20 based on the stipulations of the parties, the surrender of  
21 California Physician's and Surgeon's Certificate No. A29677 and  
22 permit FNP 181167 by respondent SURESH GANDOTRA, M.D., is hereby  
23 accepted by the Division of Medical Quality, Medical Board of  
24 California, State of California.

25 ///  
26 ///  
27 ///  
28 ///

1 DANIEL E. LUNGREN, Attorney General  
of the State of California  
2 MICHAEL P. SIPE, [BAR No. 47150]  
Deputy Attorney General  
3 110 West A Street, Suite 700  
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4 San Diego, California 92186-5266  
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5 Attorneys for Complainant  
6  
7

8 BEFORE THE  
9 MEDICAL BOARD OF CALIFORNIA  
10 DIVISION OF MEDICAL QUALITY  
11 DEPARTMENT OF CONSUMER AFFAIRS  
12 STATE OF CALIFORNIA  
13

14 In the Matter of the Accusation ) No. D-5389  
Against: )  
15 )  
SURESH GANDOTRA, M.D. ) ACCUSATION  
16 5725 Soto Street )  
Huntington Park, CA 92255 )  
17 )  
Physician and Surgeon )  
18 Certificate No. A29677, )  
19 Respondent. )  
20

21 COMES NOW Complainant Dixon Arnett, who as cause for  
22 disciplinary action against the above-named respondent, charges  
23 and alleges:

24 1. Complainant is the Executive officer of the Medical  
25 Board of California, Department of Consumer Affairs, State of  
26 California (hereafter the "Board"), and makes and files this  
27 accusation solely in his official capacity.



1                   LICENSE STATUS

2                   2. On or about October 10, 1975, Suresh Gandotra,  
3 M.D., (hereafter "respondent"), was issued Physician and Surgeon  
4 Certificate No. A29677 was issued by the Board authorizing him to  
5 practice medicine in the State of California. At all times  
6 relevant herein, said Physician's and Surgeon's Certificate was,  
7 and currently is, in full force and effect. Respondent is not  
8 authorized to supervise physician's assistants.

9                   3. *Jurisdiction.* Section 2220 of California's  
10 Business and Professions Code [hereafter, "the Code"] provides,  
11 in pertinent part, that the Division of Medical Quality may take  
12 action against all persons guilty of violating any of the  
13 provisions of the Medical Practice Act (Chapter 5 of Division 2  
14 of the Code). Section 2227 of the Code provides that a licensee  
15 whose matter has been heard by the Division of Medical Quality,  
16 by a medical quality review committee or a panel of such  
17 committee, or by an administrative law judge, or whose default  
18 has been entered, and who is found guilty may:

19                   (1) have his/her certificate revoked upon order of the  
20 division;

21                   (2) have his/her right to practice suspended for a  
22 period not to exceed one year upon order of the division or a  
23 committee or panel thereof;

24                   (3) be placed on probation upon order of the division  
25 or a committee or panel thereof;

26                   (4) be publicly reprimanded by the division or a  
27 committee or panel thereof; and/or

1 (5) have such other action taken in relation to  
2 discipline as the division, a committee or panel thereof, or an  
3 administrative law judge may deem proper.

4 4. *Summary of Allegations.* This Accusation is  
5 brought, and respondent is subject to disciplinary action,  
6 pursuant to the following sections of the Medical Practice Act:

7 A. Code sections 2234(a) and (e) provide as follows:

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

13 "(a) Violating or attempting to violate, directly  
14 or indirectly, or assisting in or abetting the  
15 violation of, or conspiring to violate, any provision  
16 of this chapter.

17 ". . . ."

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

22 B. Code section 2236 provides, in pertinent part, as  
23 follows:

24 "(a) The conviction of any offense substantially  
25 related to the qualifications, functions or duties of a  
26 physician and surgeon constitutes unprofessional  
27 conduct within the meaning of this chapter. The record

1 of conviction shall be conclusive evidence only of the  
2 fact that the conviction occurred.

3 "(b) The division may inquire into the  
4 circumstances surrounding the commission of the crime  
5 in order to fix the degree of discipline or to  
6 determine if such conviction is of an offense  
7 substantially related to the qualifications, functions,  
8 or duties of a physician and surgeon. A plea or  
9 verdict of guilty or a conviction following a plea of  
10 nolo contendere made to a charge substantially related  
11 to the qualifications, functions, or duties of a  
12 physician and surgeon is deemed to be a conviction  
13 within the meaning of this section."

14 **ALLEGATIONS**

15 **FACTS**

16 5. Respondent has subjected his license to discipline  
17 under Business and Professions Code sections 2234(a), 2234(e),  
18 and 2236, more particularly alleged as follows:

19 On or about May 2, 1990, respondent was convicted of  
20 seventeen felonies including four counts of aiding and abetting  
21 the forgery of a prescription, two counts of aiding and abetting  
22 the unauthorized practice of medicine, one count of aiding and  
23 abetting the furnishing of a dangerous drug without an authorized  
24 prescription, two counts of aiding and abetting the unlawful  
25 prescription of a controlled substance, one count of aiding and  
26 abetting the furnishing of a controlled substance, five counts of  
27 presenting a false Medi-Cal claim, one count of grand theft, and

1 one count of conspiring to present false Medi-Cal claims. The  
2 above offenses occurred from January 1, 1985 through July 13,  
3 1988.

#### 4 DISHONESTY AND CORRUPTION

5 6. Business and Professions Code section 2234,  
6 subdivision (e), defines unprofessional conduct for which the  
7 Division of Medical Quality may discipline a licentiate to  
8 include "the commission of any act involving . . . dishonesty or  
9 corruption which is substantially related to the qualifications,  
10 functions, or duties of a physician and surgeon."

11 7. Respondent is also subject to disciplinary action  
12 pursuant to section 2234 for unprofessional conduct, as defined  
13 by subdivision (e) of that section, in that the matters set forth  
14 above at paragraph 5 disclose that he committed acts involving  
15 dishonesty or corruption which were substantially related to the  
16 functions and duties of a physician when he aided and abetted  
17 forgery of prescriptions, unauthorized practice of medicine,  
18 unlawful furnishing of dangerous drugs and controlled substances,  
19 presenting of false Medi-Cal claims, grand theft and conspiracy  
20 from January 1, 1985 through July 13, 1988.

#### 21 *Conviction of an Offense*

22 8. Business and Professions Code section 2236 defines  
23 as unprofessional conduct "[t]he conviction of any offense  
24 substantially related to the qualifications, functions, or duties  
25 of a physician and surgeon . . . ."

26 9. Respondent is also subject to disciplinary action  
27 for unprofessional conduct pursuant to section 2234, subdivision

1 (a), and section 2236 in that the matters alleged above at  
2 paragraph 5 show that he was convicted of an offense as follows:


3 On July 22, 1990, respondent was convicted by jury  
4 verdict of 17 felony counts including charges of aiding and  
5 abetting forgery of prescriptions, unauthorized practice of  
6 medicine, unlawful furnishing of dangerous drugs and controlled  
7 substances, presenting false Medi-Cal claims, grand theft, and  
8 conspiracy. On May 2, 1990, in Los Angeles Superior Court,  
9 respondent was sentenced to a term in state prison on the above  
10 convictions.

11 WHEREFORE, Complainant requests that a hearing be held  
12 on the matters alleged herein, and that following said hearing,  
13 the Board issue a decision:

14 1. Revoking or suspending Physician and Surgeon  
15 Certificate No. A29677, issued to respondent, Suresh Gandotra,  
16 M.D.; and

17 2. Taking such other and further action as the Board  
18 deems appropriate.

19 Dated: 9-23-93

20  
21   
22 \_\_\_\_\_  
23 DIXON ARNETT  
24 Executive Director  
25 Medical Board of California  
26 Department of Consumer Affairs  
27 State of California

Complainant

1 DANIEL E. LUNGREN, Attorney General  
of the State of California  
2 MARGARET A. LAFKO,  
Deputy Attorney General, State Bar No. 105921  
3 Department of Justice  
110 West A Street, Suite 1100  
4 Post Office Box 85266  
San Diego, California 92186-5266  
5 Telephone: (619) 645-2064  
6 Attorneys for Petitioner

**E I L E D**  
KENNETH E. MARTONE  
Clerk of the Superior Court

DEC 16 1994

By: PAK Deputy

7  
8 **SUPERIOR COURT OF THE STATE OF CALIFORNIA**  
9 **SOUTH BAY JUDICIAL DISTRICT, COUNTY OF SAN DIEGO**

10 MEDICAL BOARD OF CALIFORNIA, )  
11 DIVISION OF MEDICAL QUALITY, )  
12 DEPARTMENT OF CONSUMER AFFAIRS, )  
STATE OF CALIFORNIA, )

13 Petitioner, )

14 v. )

15 )  
16 SURESH GANDOTRA, M.D., dba )  
EL NORTE CLINICA MEDICA, )

17 Respondent. )  
18 )  
19 )  
20 )  
21 )  
22 )  
23 )  
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26 )  
27 )  
28 )

NO. SB0003401

*EX PARTE* PETITION FOR  
TEMPORARY RESTRAINING  
ORDER

(\$125.7 Bus. & Prof.  
Code; § 525, et seq. Code  
of Civ. Proc.)

DATE: DECEMBER 16, 1994  
TIME: 8:30 A.M.  
DEPT: D, SOUTH BAY  
BRANCH

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1 DANIEL E. LUNGREN, Attorney General  
of the State of California  
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5 Telephone: (619) 645-2064  
6 Attorneys for Petitioner

7  
8 SUPERIOR COURT OF THE STATE OF CALIFORNIA  
9 SOUTH BAY JUDICIAL DISTRICT, COUNTY OF SAN DIEGO

10	MEDICAL BOARD OF CALIFORNIA,	)	NO.
11	DIVISION OF MEDICAL QUALITY,	)	
12	DEPARTMENT OF CONSUMER AFFAIRS,	)	EX PARTE PETITION FOR
13	STATE OF CALIFORNIA,	)	TEMPORARY RESTRAINING
		)	ORDER
13	Petitioner,	)	
		)	(\$125.7 Bus. & Prof.
14	v.	)	Code; § 525, et seq. Code
		)	of Civ. Proc.)
15		)	
16	SURESH GANDOTRA, M.D., dba	)	DATE: DECEMBER 16, 1994
17	EL NORTE CLINICA MEDICA,	)	TIME: 8:30 A.M.
		)	DEPT: D, SOUTH BAY
18	Respondent.	)	BRANCH

19 The Division of Medical Quality of the Medical Board of  
20 California, Department of Consumer Affairs, State of California,  
21 by and through its counsel, Daniel E. Lungren, Attorney General,  
22 by Margaret A. Lafko, Deputy Attorney General, alleges:

23 1. At all times relevant herein, the Division of  
24 Medical Quality, has been and now is, a duly constituted division  
25 of the Medical Board of California, ("petitioner" or "Board") and  
26 is a division within the Department of Consumer Affairs pursuant  
27 to sections 2001 and 2003 of the Business and Professions Code  
28 and petitioner is charged with the enforcement of Chapter 5 of



1 Division 2 of the Business and Professions Code (§§ 2000, et  
2 seq.; hereinafter the "Medical Practice Act").

3           2. Petitioner is authorized pursuant to sections 2312  
4 and 125.7 of the Business and Professions Code to seek and obtain  
5 an injunction or other order restraining a physician and surgeon,  
6 licensed by the Medical Board of California, who has violated, or  
7 is about to violate, the Medical Practice Act, from engaging in  
8 the practice of medicine, or any part thereof, when said practice  
9 will endanger the public health, safety or welfare, by  
10 application to the superior court of the county in which said  
11 violations have occurred.

12           3. Section 125.7, subdivision (d), of the Business  
13 and Professions Code provides, in pertinent part, that when a  
14 restraining order is issued pursuant to said section, an  
15 accusation shall be filed before the Board and served upon the  
16 respondent not more than thirty (30) days after the issuance of  
17 the restraining order. Said section further provides that if the  
18 respondent requests a hearing on the accusation, the petitioner  
19 must provide the respondent with a hearing within thirty (30)  
20 days of said request, and issue a decision within fifteen (15)  
21 days from the date of the conclusion of the hearing, or the Court  
22 may dissolve the restraining order.

23           4. On September 10, 1975, respondent Suresh Gandotra,  
24 M.D., (hereinafter "respondent") was issued Physician's and  
25 Surgeon's Certificate No. A29677 by the Medical Board of  
26 California. On September 23, 1993, an Accusation was filed  
27 against respondent's certificate based on the felony conviction  
28 described herein; this Accusation is pending. (Lgmt. 1 & 2.)

1           5.    The majority of the alleged violations of law  
2 described hereinafter have occurred within the County of  
3 San Diego, wherein respondent maintained an office at 342  
4 San Ysidro Blvd., Suite N., San Ysidro, California, doing  
5 business as El Norte Clinica Medica ("Clinic"). (Lgmt. 1.)  
6 Respondent performs only abortions at this clinic. (Decl. 2.)

7           6.    Business and Professions Code section 2004  
8 provides, inter alia, that petitioner has responsibility for the  
9 enforcement of disciplinary and criminal provisions of the  
10 Medical Practice Act and for reviewing the quality of medical  
11 practice carried out by physician and surgeon certificate  
12 holders.

13           7.    Respondent has violated the following provisions  
14 of the Medical Practice Act:

15           A.    Business and Professions Code section 2227  
16 provides that the certificate of a licensee may be revoked,  
17 suspended, or placed on probation.

18           B.    Business and Professions Code section 2234  
19 provides that:

20                   "The Division of Medical Quality shall take  
21 action against any licensee who is charged with  
22 unprofessional conduct. In addition to other  
23 provisions of this article, unprofessional conduct  
24 includes, but is not limited to, the following:

25                   (a) Violating or attempting to violate,  
26 directly or indirectly, or assisting in or  
27 abetting the violation of, or conspiring to  
28 violate, any provision of this chapter.

- 1 (b) Gross negligence;
- 2 (c) Repeated negligent acts;
- 3 (d) Incompetence;
- 4 (e) The commission of any act involving
- 5 dishonesty or corruption which is
- 6 substantially related to the qualifications,
- 7 functions, or duties of a physician and
- 8 surgeon.

9 . . . ."

10 C. Business and Professions Code section 2236

11 provides that conviction of a crime related to the  
12 qualifications, functions, or duties of a physician and surgeon  
13 constitutes unprofessional conduct.

14 8. Respondent is alleged to have violated provisions  
15 of the Medical Practice Act as contained in sections 2234 and  
16 2236 of the Business and Professions Code as follows:

17 9. CONVICTION

18 A. On or about May 2, 1990, respondent was  
19 convicted of seventeen felonies including four counts of aiding  
20 and abetting the forgery of a prescription, two counts of aiding  
21 and abetting the unauthorized practice of medicine, one count of  
22 aiding and abetting the furnishing of a dangerous drug without an  
23 authorized prescription, two counts of aiding and abetting the  
24 unlawful prescription of a controlled substance, one count of  
25 aiding and abetting the furnishing of a controlled substance,  
26 five counts of presenting a false Medi-Cal claim, one count of  
27 grand theft, and one count of conspiring to present false Medi-  
28 Cal claims. The above offenses occurred from January 1, 1985

1 through July 13, 1988. On May 2, 1990, in the Los Angeles  
2 Superior Court, respondent was sentenced to a term in state  
3 prison on the above convictions. (Lgmt. 3.)

4 10. PATIENT A.L.G.

5 A. A.L.G., a 22 year old resident of Tijuana,  
6 sought an abortion from respondent. She was in her eighteenth  
7 week of gestation, her second trimester. Respondent agreed to  
8 perform the abortion at his clinic in San Ysidro even though he  
9 had not received training in performing second trimester  
10 abortions (Exh. 3), and even though he did not have procedures in  
11 place to deal with the potential complications attendant to  
12 second trimester abortions.

13 B. In connection with the abortion, respondent  
14 had A.L.G. sign a consent form for a first trimester abortion.  
15 (Decl. 3.) He did so even though second trimester abortion  
16 complication rates are three to four times higher than those for  
17 first trimester abortions (Decl. 4), and even though the  
18 procedure for second trimester abortions differs from the  
19 procedure for first trimester abortions. (Decl. 3.)

20 C. On May 2, 1991, respondent took the first  
21 steps to perform the second trimester abortion on patient A.L.G.  
22 by doing a laminaria placement. A.L.G. returned to respondent's  
23 office the next day (May 3, 1991) for the actual abortion.  
24 Respondent began the abortion, but did not complete it because he  
25 could not evacuate the patient. Instead, respondent sent the  
26 patient home without medication so that "hopefully" the fetus  
27 would drop. (Decl. 3.)

28 ///

1                   D.    On May 4, 1991, A.L.G. returned to  
2 respondent's clinic for completion of the abortion. She was then  
3 suffering from an infection (Decl. 3), thereby making the uterus  
4 easier to perforate. (Decl. 4.) Nevertheless, respondent  
5 attempted, without success, to complete the abortion. (Decl. 3.)

6                   E.    In his unsuccessful attempt to complete the  
7 abortion of May 4, 1991, respondent, by his own admission,  
8 perforated the uterus. (Decl. 3.) Respondent called UCSD  
9 Medical Center and spoke with Dr. Johnson. He told her that he  
10 had a patient whose uterus he thought he had perforated during an  
11 attempted abortion. He said that he thought that he had removed  
12 some maternal omentum (part of the mother's intestine) along with  
13 fetal parts. He said the patient was sedated with Droperidol,  
14 Demerol, Nitrous Oxide and Valium. He said the patient was  
15 stable with a blood pressure of 110/70 and a pulse of 72 and that  
16 she was not actively bleeding. He did not tell her that the  
17 patient was on a dopamine drip. Given that the patient was  
18 reported as stable, she authorized him to transport the patient  
19 from San Ysidro to UCSD Medical Center rather than the nearest  
20 hospital. (Decl. 4.)

21                   F.    When A.L.G. arrived at UCSD Medical Center at  
22 4:15 p.m., she was examined by Dr. Donna Johnson. Dr. Johnson  
23 found the patient to be in hemorrhagic shock, having suffered a  
24 blood loss of at least 40 percent of her total blood volume as  
25 indicated by her vital signs upon presentation. Contrary to the  
26 representation of the respondent, the patient was not stable. In  
27 fact, the patient had been on a Dopamine drip when the paramedics

28    ///

1 arrived at the clinic. The patient was in immediate need of  
2 surgery. (Decl. 4.)

3 G. Dr. Johnson, with Dr. Elaine Hanson attending,  
4 performed surgery. During the surgery, it was determined that  
5 the patient had a 3 centimeter cervical laceration that extended  
6 4 centimeters into the upper part of the vagina and a 5  
7 centimeter laceration in the dome of the bladder. The damage to  
8 the patient was so extensive it was difficult to identify her  
9 anatomy. Dr. Johnson removed the fetal parts and placenta which  
10 had been left in the patient by respondent. She then repaired  
11 the seven centimeter tear of the cervix and vagina. Drs. Sayer  
12 and Demby repaired the patient's bladder. (Decl. 4.)

13 H. On August 7, 1992, during a telephone  
14 conversation with Medical Board Senior Investigator M. Dennis  
15 Rodriguez regarding patient A.L.G., respondent stated, "I guess I  
16 screwed up." (Decl. 3.)

17 I. Respondent's treatment of patient A.L.G. was  
18 reviewed by Dr. Lidia Rubinstein (Decl. 5) and Dr. Benson Harer  
19 (Decl. 6). Dr. Rubinstein concluded it was negligent and  
20 incompetent. Dr. Harer concluded respondent's treatment was  
21 grossly negligent.

22 J. Respondent's care and treatment of patient  
23 A.L.G. constituted repeated negligent acts and gross negligence  
24 in that:

25 1) by agreeing to perform the abortion without  
26 proper training and without proper arrangements having  
27 been made to treat the patient in the event  
28 complications arose, respondent departed from the

1 standard of care owed to second trimester abortion  
2 patients (See Decl. 4); 2) by sending patient A.L.G.  
3 home after the first day's failed abortion attempt  
4 rather than completing the abortion himself or having  
5 it completed by another physician in a proper facility,  
6 respondent engaged in an extreme departure from the  
7 standard of care by subjecting the patient to  
8 dramatically increased risk of infection thereby making  
9 the uterus more easy to perforate; by subjecting the  
10 patient to the risk of a concealed hemorrhage, which  
11 occurs in the uterus behind the fetus or placenta and  
12 is not detected because no blood comes from the vagina;  
13 and, by subjecting the patient to an increased risk of  
14 developing disseminated intravascular coagulopathy, a  
15 condition that makes it impossible to operate without  
16 the risk of excessive bleeding (Decl. 4); 3) by failing  
17 to tell Dr. Johnson that patient A.L.G. was on a  
18 dopamine drip prior to being transported, respondent  
19 departed from the standard of care (Decl. 4); and, 4)  
20 by having patient A.L.G. sign a consent form for first  
21 trimester abortions even though she was to undergo a  
22 second trimester abortion, respondent departed from the  
23 standard of care through negligence (Decl. 5) or  
24 dishonesty.

25 11. PATIENT M.O.R.

26 A. Patient M.O.R., a resident of Tijuana, was 23  
27 years old when she was treated by the respondent in his clinic on  
28 December 7 and 8, 1994, for a therapeutic abortion. Respondent

1 believed her uterus to be enlarged to 22 weeks when he commenced  
2 the procedure. She arrived at the clinic at 9:27 a.m. (Lgmt. 4,  
3 pp. 103-108.)

4 B. Respondent began the abortion procedure at  
5 approximately 10:00 a.m. on December 8, 1994. At 11:30 a.m., he  
6 was having difficulty extracting all the fetal parts and he  
7 stopped the procedure. He removed her from the operating room  
8 ("OR") to a bed in another room. Respondent took M.O.R. back  
9 into the operating room at approximately 1:30 p.m. Within ten  
10 minutes, he realized he perforated the uterus. He saw that he  
11 had removed bowel parts. He told the Board investigators, "I  
12 knew I screwed up." (Decl. 7 & 8.)

13 C. At 3:24 p.m., respondent spoke with Dr.  
14 Silverman, a resident gynecologist at UCSD Medical Center, and  
15 described the condition of his patient. (Decl. 9 & 10.) He told  
16 Dr. Silverman that she was 24 weeks gestation, that he had  
17 removed 'the fetus' arms, and that he was unable to evacuate the  
18 remainder. Respondent said "I think I lacerated the cervix  
19 getting the arms out." When asked if she was bleeding,  
20 respondent said "I think she may need blood." At some point,  
21 respondent said "I screwed up." (Decl. 10.)

22 D. Respondent asked directions to the hospital  
23 to send her by car, but was told "You have to put her in an  
24 ambulance right now." Dr. Silverman agreed on behalf of UCSD to  
25 accept transfer of M.O.R. and gave respondent the name and  
26 telephone number for Dr. Tipton at Labor and Delivery to make  
27 arrangements for M.O.R. (Decl. 10.)

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1                   E.    When Dr. Tipton spoke with Dr. Gandotra at  
2 3:46 p.m. on December 8, 1994, regarding the condition of this  
3 patient for transport to UCSD, Dr. Gandotra stated that he had  
4 started a D&E in the office and had removed the upper extremities  
5 and immediately noted bleeding. He was unsure if he had  
6 lacerated the cervix or perforated the uterus. He said that she  
7 was not bleeding when she was lying down, though if she stood up,  
8 she had some bleeding. He said that her blood pressure was 90/70  
9 and when asked what it was prior to the procedure, he said it had  
10 been 110/80. He said that she had received 20 milligrams of  
11 Valium, had an I.V., and was receiving D5NS. Dr. Gandotra told  
12 Dr. Tipton that she was stable for transport to UCSD from San  
13 Ysidro. Dr. Tipton told Dr. Gandotra that she should come  
14 directly by ambulance to Labor and Delivery. At no time did Dr.  
15 Tipton advise Dr. Gandotra to call a "private" ambulance.  
16 (Decl. 11.)

17                   F.    UCSD Medical Center made preparations for her  
18 arrival; the trauma surgeon, the urologist, and the  
19 anesthesiologist were notified of her pending arrival. "Trauma"  
20 blood was readied for an immediate transfusion. The staff  
21 obstetrician/gynecologist qualified to perform 24 week  
22 terminations was also ready and they were all waiting on Labor  
23 and Delivery for her arrival. By 4:30 p.m., she still had not  
24 arrived, but the receptionist received a call from an ambulance  
25 service to confirm that UCSD had agreed to accept the patient;  
26 verbal communication was given. At 6:10 p.m., she still had not  
27 arrived and UCSD called Scripps Chula Vista Emergency Room to see  
28 if she had been taken there. It was confirmed that the patient

1 had been admitted to the ER and Dr. Vandenberg at Scripps  
2 confirmed to Dr. Tipton that the patient had been in ventricular  
3 fibrillation when the paramedics arrived at the clinic. He had  
4 not received any history about the patient's circumstances,  
5 (i.e., whether it was drug related or procedure related) and  
6 stated that the history given by Dr. Tipton regarding the  
7 bleeding at the clinic was helpful. A cardiac resuscitation had  
8 been initiated by the time of Dr. Tipton's conversation with Dr.  
9 Vandenberg. The patient had a diastolic pressure of 40, had  
10 cardiac electrical activity, had received six units of red blood  
11 cells, and remained with fixed and dilated pupils. She was  
12 bleeding from her vagina and the urethra with unclotting blood  
13 and was presumed to be in DIC (disseminated intravascular  
14 coagulation). The obstetrician/gynecologist on call had been  
15 notified and was en route but Dr. Vandenberg stated that her  
16 progress was poor. (Decl. 11.)

17 G. After speaking with Dr. Silverman and Dr.  
18 Tipton, respondent told Board investigators that he tried to call  
19 a private ambulance and couldn't get one. A while later, the  
20 patient's condition worsened and 911 was called from the clinic.  
21 (Decl. 7 & 8.) At 4:25 p.m. on December 8, 1994, American  
22 Ambulance paramedics were called to the clinic, arriving at  
23 4:33 p.m. (Lgmt. 5.) Paramedics found her in cardiac arrest  
24 bleeding down on the floor with no pulse. (Lgmt. 4, pp. 89, 94.)  
25 She was intubated and defibrillated and en route CPR continued,  
26 as well as medications and fluids. (Lgmt. 4, p. 94.) CPR was  
27 continued en route to the emergency room at Scripps Memorial  
28 Hospital, Chula Vista. (Lgmt. 4, p. 94.)

1 H. The patient arrived in the emergency room at  
2 5:14 p.m., and had no vital signs. (Lgmt. 4, p. 94.) She was  
3 unresponsive with fixed and dilated pupils. She was in an  
4 idioventricular rhythm on the cardiac monitor without pulses or  
5 spontaneous respirations. (Lgmt. 4, p. 97.) At 5:27 p.m., a  
6 carotid pulse was felt with a sinus rhythm noted on the cardiac  
7 monitor. (Lgmt. 4, p. 97.) She was infused with multiple units  
8 of packed red blood cells and transported to surgery at  
9 7:30 p.m. (Lgmt. 4, pp. 97-99.)

10 I. Upon completion of an exploratory laparotomy  
11 incision, a massive amount of blood gushed out. Dr. Arguiano,  
12 OB/Gyn surgeon, (with Dr. Gracia also present during surgery),  
13 noted a large uterine laceration with a fetal lower extremity  
14 protruding out and into the abdominal cavity. He also noted a  
15 surgical sponge in the uterus. There were cervical, vaginal and  
16 bladder lacerations noted. A female fetus was removed and noted  
17 by Dr. Anguiano to be approximately 30 weeks gestational age.  
18 The upper extremities and internal organs were traumatically  
19 missing. Patient M.O.R.'s rectal sigmoid flexure was avulsed  
20 from the mesentery requiring resection from the anal rectal  
21 junction to the descending sigmoid. Areas of necrosis and  
22 hematomas were noted. A supra cervical hysterectomy was  
23 performed. Despite aggressive surgical and fluid resuscitative  
24 efforts, M.O.R.'s condition deteriorated throughout surgery.  
25 (Lgmt. 4, p. 62; Decl. 12 & 13.)

26 J. Following surgery, she was transported to  
27 surgical intensive care where her condition continued to  
28 deteriorate. At 10:17 p.m., she was absent of pulse,

1 respirations, and blood pressure and at that time, was declared  
2 dead. (Lgmt. 4, p. 64-79.)

3 K. The pertinent records and declarations herein  
4 concerning respondent's care and treatment of patient M.O.R. have  
5 been reviewed by Dr. Swartz, a Board certified physician in  
6 Obstetrics and Gynecology and a Clinical Professor of  
7 Reproductive Medicine at the University of California at San  
8 Diego. Dr. Swartz has been performing abortions for more than  
9 twenty years and performs abortions at all legal gestational  
10 ages. (Decl. 14.)

11 L. In his review of the pertinent records  
12 herein, Dr. Swartz has constructed a chronological history  
13 concerning this patient beginning with her visit to the clinic on  
14 December 7, 1994, at which time the laminaria were inserted for  
15 the following day's procedure, and continuing through December 8,  
16 1994, when she died at 10:17 p.m. at the hospital. (Decl. 14.)

17 Based upon his review, Dr. Swartz has found significant  
18 departures from the standard of care:

19 "a. There was a failure to perform and/or record  
20 a pre-operative history and physical.

21 "b. There was a failure to perform and/or record  
22 a pre-operative hematocrit or hemoglobin.

23 "c. There was a failure to perform and/or record  
24 an ultrasound exam to accurately establish gestational  
25 age prior to performing an abortion beyond 14 weeks.

26 "d. There was a failure of the operating surgeon  
27 to have hospital privileges at an emergency hospital  
28 within a reasonable distance of the surgical facility.

1 "e. There was a failure of the operating surgeon  
2 to have a written transfer agreement with an emergency  
3 hospital.

4 "f. There was a failure of the operating surgeon  
5 to have an established plan for handling emergency  
6 complications of a procedure noted for risk of serious  
7 complications. This is despite a similar complication  
8 one year ago.

9 "g. There was a failure to have sufficient staff  
10 to assist with complications of surgery and/or monitor  
11 the post-operative recovery phase of surgical patients.

12 "h. There was a failure to perform and/or record  
13 intraoperative findings, monitoring and treatment.

14 "i. There was a failure to perform and/or record  
15 post-operative findings, monitoring and treatment.

16 "j. There was an extreme delay in initiating  
17 appropriate treatment and transfer following the  
18 recognition of the serious surgical complication."

19 (Decl. 14.)

20 M. Dr. Swartz has concluded that the above  
21 significant departures from the standard of care individually and  
22 collectively represent serious and major departures from the  
23 standard of care and contributed to the death of this patient.

24 (Decl. 14.)

25 N. Respondent's conduct as set forth hereinabove  
26 in paragraphs 9, 10, and 11 constitutes acts of unprofessional  
27 conduct in violation of sections 2234 and 2236 of the Business  
28 and Professions Code in that respondent has been convicted of a

1 felony related to the practice of medicine and is guilty of gross  
2 negligence, incompetence, and repeated negligent acts in  
3 performing abortions on these two patients, resulting in serious  
4 injury and death.

5           12.   RESPONDENT'S QUALIFICATIONS AND PROCEDURES  
6                IN PERFORMING ABORTIONS AND HIS STATEMENTS  
7                REGARDING PATIENT M.O.R.

8           A.    In a conversation on December 9, 1994, with  
9 Dr. Moore, Director of Perinatal Medicine at UCSD, respondent  
10 claimed that he performs over 100 abortion procedures each week  
11 and that he has been doing this for 20 years. He has not been  
12 trained in abortion procedures and he is not an OB/Gyn physician,  
13 but rather an emergency medical physician who stated that he  
14 "came into this work because patients needed me." (Decl. 15.)  
15 Respondent does not have any admitting privileges at any hospital  
16 and he does not have any transportation relationships in place  
17 for his patients to be transferred to a hospital in the event of  
18 a complication or emergency. (Decl. 15.)

19           B.    Regarding patient M.O.R., Dr. Gandotra  
20 admitted to Dr. Moore that she began bleeding during the  
21 procedure and that he recognized it was excessive and called UCSD  
22 Medical Center to transport her there. He said that the patient  
23 would not allow him to do this and that she actually wanted to  
24 get up and walk home. When asked if he had back-up or  
25 transportation agreements for his patients, he stated: "I prefer  
26 my patients go to University and that's who I called first."  
27 (Decl. 15.)

28           C.    He stated that after he finished calling the  
University on the afternoon of December 8, 1994, he went back to

1 check on M.O.R. She was looking worse and he was also checking  
2 on other patients, going room to room, and when he came back to  
3 check M.O.R. again she was in shock or coding, and he  
4 administered mouth-to-mouth resuscitation, then intubated, and  
5 started CPR. Dr. Gandotra stated that he was working on M.O.R.  
6 and doing CPR when the ambulance arrived and he directed them to  
7 Scripps Hospital in Chula Vista. (Decl. 15.)

8 D. When asked why he did not ride with M.O.R. in  
9 the ambulance to the hospital, respondent stated initially that  
10 he did not have privileges at that hospital. When asked a second  
11 time why he did not accompany the patient, he stated that "he had  
12 other patients to watch." (Decl. 15.)

13 14. AUTOPSY OF M.O.R. AND INFANT

14 A. Christopher I. Swalwell, M. D. is the medical  
15 examiner who performed the autopsy on patient M.O.R. and her baby  
16 on December 9 and 10, 1994. Of the 3,000 autopsies he has  
17 performed, approximately 100 included fetuses, newborns, and  
18 stillborns in which he determined gestational age. Dr. Swalwell  
19 concluded that the baby was approximately 26 to 28 weeks  
20 gestation. The baby died as a result of the therapeutic  
21 abortion. The body of the baby was not complete when autopsied.  
22 Both arms had been cut off; the heart, lungs, liver, and other  
23 organs had been cut out, the front of the chest and abdomen were  
24 missing, the right femur was fractured, the head was intact  
25 except for an area on the scalp which had been taken off from the  
26 back of the head. The autopsy photos, which are attached to Dr.  
27 Swalwell's Declaration, depict the mother and baby. (THESE

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1 PHOTOS WILL BE PROVIDED TO THE COURT AT THE HEARING AND ARE NOT  
2 FILED HEREIN.) (Decl. 16.)

3 B. Dr. Swalwell has tentatively opined that the  
4 cause of death on M.O.R. was complications of the acute pelvic  
5 injuries which consisted of lacerations of the lower uterus,  
6 vagina, bladder and colon. (Decl. 16.)

7 15. EL NORTE CLINICA MEDICA

8 A. Respondent practices medicine in San Diego  
9 County at the El Norte Clinica Medica where he performs  
10 abortions. No other medical practice is provided at the clinic.  
11 Respondent is the only physician who practices in the clinic and  
12 he has one employee, Shirley Riles, who acts as an office  
13 manager. On December 13, 1994, Dr. Buncher toured the clinic  
14 with Ms. Riles who provided information regarding the clinic's  
15 operation. She greets patients, explains procedures, obtains the  
16 medical consent, and initial intake information. She speaks  
17 English and Spanish and has no medical training. The clinic  
18 consists of a reception area, a recovery room, a treatment room,  
19 and a bathroom, all connected by a single hallway. (Decl. 2 &  
20 17.)

21 B. No blood or blood products are maintained at  
22 the clinic. Lab work performed at the clinic consists of  
23 pregnancy tests and tests for the RH factor, done by Ms. Riles.  
24 No other preoperative or post-operative lab tests are done.  
25 Tissue specimens are not sent out for examination and evaluation.  
26 There is no area in the clinic for lab work. The medical records  
27 used in the clinic consist of three full sheets of paper and two  
28 half sheets. The full sheets contain the consent form, a



1 procedure description with pre-op and post-op instructions, and  
2 an advisement sheet with instructions about what the patient  
3 should do in case of complications. The consent form only covers  
4 pregnancies done in the first thirteen weeks of gestation. The  
5 consent form implies that trained medical personnel, other than  
6 just Dr. Gandotra, work at the facility, that special diagnostic  
7 procedures are available to the patient, and that tissue is  
8 examined by a pathologist. Ms. Riles records the patient's last  
9 menstrual period (LMP), her RH status, and other intake  
10 information. This same half sheet is then used by Dr. Gandotra  
11 for his notes. No other records are used or kept. (Decl. 17.)

12 C. Respondent does his own anesthesia and uses  
13 Droperidol, Nitrous Oxide, and Oxygen. After the abortion, Ms.  
14 Riles checks on the patients and asks whoever accompanied the  
15 patient to sit with the patient. The patient is instructed to  
16 return to the clinic after two weeks for follow-up.  
17 Approximately 20 percent of the patient caseload returns for the  
18 follow-up visit. Patients are not contacted if they miss a  
19 follow-up because often the names and phone numbers given are  
20 fictitious. Patients are told to call for excessive pain or  
21 bleeding yet the clinic does not take after hours calls.  
22 Consequently, if a patient experiences problems after hours, the  
23 patient is told to call an emergency room. Respondent has no  
24 back-up physician, does not take after hours calls, and does not  
25 have any hospital privileges. (Decl. 17.)

26 D. All of these facts demonstrate that  
27 respondent is practicing well below the standard of care and in a  
28 grossly negligent manner. Inadequate patient identification

1 information is obtained. No log of patients treated is  
2 maintained. There is no form on which the patient may self-  
3 identify any past medical problems or family history. An  
4 appropriate history and physical are not done nor is any  
5 preoperative lab work obtained. The consent form is misleading  
6 and inadequate. The patients are virtually abandoned by Dr.  
7 Gandotra after the procedure is completed because he does not  
8 take after hours calls nor does he have back-up. Dr. Gandotra is  
9 not assisted by any trained medical personnel. Ninety-five (95)  
10 percent of the patients are Spanish- speaking, yet respondent  
11 does not speak Spanish. Respondent's practice of medicine in  
12 this setting and the operation of the clinic endangers the public  
13 health, safety and welfare. (Decl. 17.)

14 WHEREFORE, petitioner prays that this court grant  
15 relief as follows:

16 1. That respondent Suresh Gandotra, M.D. be  
17 restrained and enjoined by way of a temporary restraining order  
18 pursuant to Business and Professions Code section 125.7 from  
19 practicing or attempting to practice medicine, advertising or  
20 holding himself out as practicing any system or mode of treating  
21 the sick or afflicted of this state, or diagnosing, treating,  
22 operating for, or prescribing for any ailment, blemish,  
23 deformity, disease, disfigurement, disorder, injury, or other  
24 physician or mental condition of any person or in any other  
25 manner or means of practicing medicine, until a hearing can be  
26 held on the Accusation filed with the Medical Board pursuant to  
27 Business and Professions Code section 125.7(d) and the

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1 Supplemental Accusation which will be filed alleging the grossly  
2 negligent treatment of these two patients.

3 2. That El Norte Clinica Medica be closed and that  
4 respondent be restrained from any future control of its  
5 operations as a medical office, clinic, or other medical  
6 facility.

7 3. That the petitioner have such other and further  
8 relief as the nature of the case may require and the court deems  
9 appropriate to protect the public health, safety, and welfare.

10 DATED: December 15, 1994

11 Respectfully submitted,

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

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15 MARGARET A. LAFKO  
16 Deputy Attorney General

17 Attorneys for Complainant

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