4 Patient Safety Home Page | Medical Board of CA | Medical Board of CA Lookup page
CA Department of Public Health | National Sex Offender Registry

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Doctor's Name	License Number	License Status
Lawson Alozie Akpulonu	31917	Revoked
City of Record Los Angeles	Region Los Angeles	License Issued 02/16/1978
Licensing Boards Medical	Specialties Abortionist	Gender Male
Accusations and Infractions or Causes for Discipline Dishonesty Fraudulent Insurance Claim False Statements In Documents Repeated Negligent Acts Gross Negligence Incompetence Failed To Follow Infection Control Guidelines Sexual Misconduct		Date of Last MBC Action 09/11/1996
Repeat Offender? Yes	Pending MBC Activity? No	Out of State Dicipline No
CMA Member? No	No Medical Board Activity?	

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Medical Board Documents, News Articles, Court Documents, Etc.	
Article: Despite criminal records and malpractice judgments, some doctors remain in practice for years 1/31/1993	
+Default Decision 1/08/1996	
+Default Decision 9/11/1996	
Article: L.A. Doctor's license is suspended in sex case 2/18/1995	
Article: Diane Sawyer and the non-story of Lawson Akpulonu 8/31/2012	

Additional Information (Medical School, Dated Actions, Excerpts from Disciplinary Actions, Notes)

NORTHWESTERN UNIVERSITY MEDICAL SCHOOL

- **9/11/1996**—**CALIFORNIA MEDICAL LICENSE REVOKED.**
- **2/28/1995**—ACCUSATION FILED.
- **12/07/1994**—SECOND AMENDED ACCUSATION FILED.
- **8/12/1993**—FIRST AMENDED ACCUSATION FILED.
- **7/02/1993**—ACCUSATION FILED.

Excerpt from Accusation dated 12/07/1994:

FIRST CAUSE OF ACTION

11. Respondent is subject to disciplinary action under Business and Professions Code sections 2234(e), 2261, 2262 and 810(a)(l), as more fully set forth below:

10. Business and Professions Code section 810 provides

a. On or about October 22, 1986 patient "S.T." visited the respondent at his Los Angeles Midland Medical Clinic for a cough. While there patient "S.T." did not have a chest x-ray or EKG. Between October 22, 1986 and December 26, 1986, **respondent willfully and unlawfully with intent to defraud presented a false or fraudulent Medi-Cal claim for payment for furnishing a chest x-ray and EKG to patient "S.T." when in fact respondent had not furnished same.**

b. On or about November 11, 1986 patient "C.C." visited the respondent at his West Washington Boulevard, Los Angeles office where she was given a pregnancy test, had blood drawn, and an abortion performed. Patient "C.C." while there did not have an x-ray taken. **Between November 11, 1986 and December 26, 1986, respondent willfully and unlawfully with intent to defraud presented a false or fraudulent Medi-Cal claim for payment for furnishing an x-ray to patient "C.C." when in fact respondent had not furnished same.**

c. On or about December 16, 1985 patient "D.C.11 visited the respondent at his Los Angeles office regarding back pain. Patient "D.C." while there did not have an x-ray taken. Between December 16, 1985 and January 16, 1986, **respondent willfully and unlawfully with intent to defraud presented a false or fraudulent Medi-Cal claim for payment for furnishing an x-ray to patient "D.C. when in fact respondent had not furnished same.**

d. On or about December 13, 1986 patient "E.C." visited the respondent at his West Washington Boulevard, Los Angeles office, where respondent took a pap smear, examined her pelvic area, and gave her an ultrasound examination. Patient "E.C." while there did not have an x-ray taken. **Between December 13, 1986 and December 22, 1986, respondent willfully and unlawfully with intent to defraud presented a false or fraudulent Medi-Cal claim for payment for furnishing an x-ray to patient "E.C." when in fact respondent had not furnished same.**

e. The facts and allegations in paragraph ll(d) above are incorporated here as if fully set forth here. On or about December 13, 1986 **respondent willfully and unlawfully with fraudulent intent altered or modified the medical record or created a false medical record of patient "E.C."**

SECOND CAUSE OF ACTION

12. Respondent is subject to disciplinary action under Business and Professions Code sections 2234(e), 2261, 2262 and 15 810(a)(l), as more fully set forth below:

a. On or after the following service dates for the 62 respective patients, Respondent willfully and unlawfully with intent to defraud presented false or fraudulent Medi-Cal claims totalling $9,300.00 for payment for furnishing obstetric douches and curretages (OB D&C), i.e., abortions, by double billing for the single procedure using two different billing codes (appropriate code 59840 for $158.10 and inappropriate code 58120 for $150 for a non-OB D&C):

[see data in original document]

THIRD CAUSE OF ACTION

13. Respondent is subject to disciplinary action under Business and Professions Code sections 2234(e), 2261, 2262 and 810(a)(l), as more fully set forth below:

a. On or after the following service dates for the 98 respective patients, Respondent willfully and unlawfully with intent to defraud presented false or fraudulent Medi-Cal claims totalling $5,970.40 for payment for $64.00 (unless otherwise noted) for new patient comprehensive visits, code 90020, when initial visits had been previously billed for the patients under code 90020:

[see data in original document]

SEVENTH CAUSE OF ACTION

33. On or about November 2, 1990, respondent undertook the care and treatment of uG.B.uY, a young female patient. Patient "G.B." went to respondent to determine if she was pregnant. Blood was drawn at respondent's clinic from the patient for a serum beta-HCG test and sent to a laboratory. The patient was advised results would be available in a couple days. The patient desired to determine that day whether she was pregnant. **Respondent advised the patient that a pelvic ultrasound could be performed to determine pregnancy. A pelvic ultrasound was performed and respondent advised the patient that she was pregnant. Respondent performed a suction D & C (dilation and curettage) on patient "G.B." on November 2, 1990. The patient obtained the results of the blood test on November 6, 1990; the results indicated she had not been pregnant.**

34. Respondent is subject to disciplinary action pursuant to sections 2234(b), 2234(c), 2234(d) and 2234(e) of the Business and Professions Code in that **he has been grossly negligent, has been repeatedly negligent, has been incompetent and has committed acts involving dishonesty or corruption which are substantially related to the qualifications, functions or duties of a physician and surgeon, in the care and treatment of "G.B.," by reason of the following:**

a. Respondent performed a suction D & C on patient "G.B." on or about November 2, 1990 without first establishing by reliable means that she was pregnant.

b. Respondent failed to obtain a positive pregnancy test before performing a suction D & C on patient "G.B." on or about November 2, 1990.

c. Respondent relied on an unreliable test, a pelvic ultrasound performed within the first trimester, as a basis for performing a suction D & C on patient "G.B." on or about November 2, 1990.

d. Respondent failed to administer a urine test to determine whether patient "G.B." was pregnant on or about November 2, 1990.

e. Respondent failed to determine patient "G.B.'s" Rh factor and to advise her regarding that on or after November 2, 1990.

f. Respondent on or after November 2, 1990 willfully and unlawfully with fraudulent intent altered or modified the medical record or created a false medical record of patient "G.B."

EIGHTH CAUSE OF ACTION

35. Respondent is subject to disciplinary action pursuant to sections 2261 and 2262 of the Business and Professions Code, as more fully set forth below:

a. The facts and allegations set forth in paragraph 34(f) above are incorporated here as if fully set forth here.

NINTH CAUSE OF ACTION
Failure to follow infection control guidelines.

45. Respondent is subject to disciplinary action pursuant to section 2221.1 of the Business and Professions Code in that **he has knowingly failed to protect patients by failing to follow infection control guidelines of the board in maintaining the offices where respondent cares for and treats patients**, by reason of the following:

46. On or about July 17, 1991, respondent's office (Midland Medical Clinic) at 3827 W. Washington Boulevard, Los Angeles, California, was inspected by representatives of the California Occupational Safety and Health agency. The inspection consisted of an on-site interview of employees of respondent and an on-site walk-through inspection of the facility. As a result of the July 17, 1991 inspection, the following deficiencies were disclosed at Respondent's Los Angeles facility:

a. Filthy rest room with no toilet paper.

b. Reports of unsterile instruments being used in operating room (OR).

c. Anesthesia equipment without scavenger equipment and strong presence of fumes long after patient procedure completed.

d. Inadequate staffing; no registered nurse (RN), only one person performing abortions.

e. No scrub room and inadequate supply of gowns and gloves.

f. Blood on floor and curtains of operating room (OR). No patients in area.

g. Unlicensed facility, fictitious name permit expired February 28, 1990 (#6077 and #5802).

h. Blood samples are discarded and not sent for lab analysis.

i. Failure to develop a written hazard communication program.

j. Failure to train employees in the requirements of an injury and illness prevention program.

47. During a two and a half week period in or around the August or September of 1991, the following conditions were observed at respondent's Midland Medical Center at 5443 West Washington Boulevard, Los Angeles, California:

a. Employees were trained to clean hoses used in medical procedures in running cold water by working the hoses manually to flush out all blood and tissue. Gloves were not worn. Employees were trained to dump tissue jars into the sink and run the contents through the garbage disposal. The tissue jar was then rinsed in cold water and air dried. All instruments were rinsed in cold water in the sink and put in the autoclave, which was rusty and too small to permit closing of the lid when the instruments were in it.

b. Products of conception were destroyed without samples being sent to a pathology laboratory.

c. Respondent reused plastic syringes during medical procedures.

d. The clinic smelled of rotting tissues, the surgery room was splattered with blood and some other rooms were filled with dust. Rat droppings were found in the surgery room and in the hall.

48. In or around the period of May 3, 1993 through May 20, 1993, the following conditions were observed at respondent's Midland Medical Center at 5443 West Washington Boulevard, Los Angeles, California:

a. Respondent did not use gloves during medical procedures and advised his medical assistants that they did not need to use gloves unless they had a cut on their finger or hand.

b. Respondent brought his entire staff into the examination room to observe a patient who had a severe case of genital warts.

c. Respondent failed to do pathology reports, or send specimens out for such reports, in termination of pregnancy procedures.

d. Respondent had no refrigeration unit at this clinic for storage of blood samples, tissue samples anrl drugs.

e. Respondent had no on-site equipment for handling emergencies.

f. Products of conception and fetal material younger than 18-24 weeks were put down the garbage disposal.

g. Respondent did not have equipment properly sterilized between procedures.

49. In or around the period of July 15, 1993 through August 2, 1993, the following conditions were observed at respondent's Midland Medical Center at 5443 West Washington Boulevard, Los Angeles, California:

a. Respondent disposed of products of conception and fetal material less than five months old by 2 flushing it down the toilet.

b. Respondent kept the clinic in poor sanitary 4 condition.

c. Employees did not receive training in universal precautions to prevent transmission of blood- borne pathogens.

d. There was no posted exposure control plan or list of jobs which involved exposure to blood-borne pathogens.

e. Respondent did not have equipment or examination rooms properly sterilized between procedures.

f. Employees assisting in medical procedures were not provided aprons, masks or hair covers.

g. Respondent reused items that should have been disposed of after their initial use such as plastic equipment inserted in patients' vaginas and tubing that transported products of conception.

h. The clinic was dirty with no cleaning service brought in to clean the clinic.

50. On or about September 16, 1993, the following conditions were observed at respondent's Midland Medical Center at 5443 West Washington Boulevard, Los Angeles, California:

a. The examination rooms had a bad smell about them.

b. The autoclave was dirty and instruments in the autoclave were rusty and dirty (crusted with tissue).

c. An employee was given a dirty piece of equipment to clean when the employee was not wearing protective gloves.

d. An employee was told by respondent words to the effect that if the employee desired to work at respondent's clinic, the employee would not wear gloved when dealing with bodily fluids.

e. An employee was told by respondent words to the effect that based on respondent's experience as a virologist and medical doctor, respondent did not want his employees wearing gloves when dealing with bodily fluids because it was not necessary.

f. An employee was told by respondent words to the effect that respondent made the rules and that if the employee insisted on wearing gloves when dealing with bodily fluids, the employee could not work in respondent's clinic.

g. An employee, who expressed an intention to report respondent's statements in subparagraph (e) above to health authorities, was told by respondent that respondent would make it respondent's duty to see that the employee never got a job in the health care field.

51. On or about February 1, 1994, respondent's office (Midland Medical Center) at 10918 Ramona Boulevard, El Monte, California, was inspected by representatives of the California Department of Industrial Relations, Division of Occupational Safety and Health. The inspection consisted of an on-site interview of respondent, an on-site interview of an employee of respondent and an on-site walk-through inspection of the facility. As a result of the February 1, 1994 inspection, the following deficiencies were disclosed at Respondent's El Monte facility:

a. The exposure control plan was inadequate, lacking sections on exposure determination and exposure incident follow-up.

b. Universal precautions were not routinely followed or maintained.

c. Sharps containers were not within easy access of exam areas and one was found with a needle protruding from the opening.

d. Blood products were improperly stored in leaking containers and improperly labeled.

e. Hand washing facilities were inadequate, lacking soap or antiseptic and towels.

f. Hazardous waste was improperly disposed of - respondent transports it himself.

g. Food was inappropriately mixed with hazardous material in the refrigerator.

h. Personal protective equipment was inadequate and should include gowns and face shields or goggles.

i. Protective resuscitative equipment to be used the oxygen tank in case of emergency was missing.

j. General housekeeping of the work site wa poor with no housekeeping schedule.

k. Training was inappropriately given by an employee with only one week of employment and did not include information on the handling of an exposure incident nor the current recommendations for Hepatitis B vaccination.

l. Record keeping was inadequate with no employee exposure or training records maintained.

m. No use of Hepatitis B declination forms for those declining vaccination.

n. Safety warnings were inadequate with no biohazard sign on the refrigerator.

o. No warning notice (MSDS) on site for the isopropyl alcohol or germafect solution used for disinfecting and cleaning instruments.

52. On or about March 15, 1994, respondent's office (Midland Medical Center) at 5443 W. Washington Boulevard, Los Angeles, California, was inspected by representatives of the California Department of Industrial Relations, Division of Occupational Safety and Health. The inspection consisted of an on-site interview of respondent, an on-site interview of employees of respondent and an on-site walk-through inspection of the facility. As a result of the March 15, 1994 inspection, the following deficiencies were disclosed at Respondent's Los Angeles facility:

a. The exposure control plan was inadequate, lacking sections on exposure determination and exposure incident follow-up.

b. Universal precautions were not routinely followed.

c. Sharps such as needle hanging from IV bottle were not properly disposed of.

d. Sharps containers were not within easy access of phlebotomy areas.

e. Blood products were improperly labeled and stored on open cupboards.

f. Hand washing facilities were inadequate, lacking towels for drying.

g. The emergency exist was blocked.

h. Personal protective equipment (PPE) was inadequate; there were no gowns, face shields or goggles.

i. Protective resuscitative equipment to be used with the oxygen tank in case of emergency was missing.

j. General housekeeping of the work site was poor and no housekeeping schedule was posted.

k. Biohazardous waste was improperly stored in paper boxes.

l. Hepatitis B vaccination was not completed in timely fashion by the employer.

m. Training was inadequate and did not include information on handling exposure incidents nor current Hepatitis B vaccination recommendations.

n. Record keeping was inadequate with no employee exposure or training records maintained.

o. Hepatitis B declination forms were not provided for those declining vaccination.

p. Safety warnings were inadequate with no biohazard sign on the autoclave.

q. Therewas no warning notices (MSDS) on site for the surgicide.

r. The maintenance room contained an unlabeled and blocked electrical panel as well as a floor covered with large wires creating a hazard.

TENTH CAUSE OF ACTION
Failure to follow infection control guidelines.
GROSS NEGLIGENCE

53. Respondent is subject to disciplinary action pursuant to sections 2234(b) of the Business and Professions Code in that **he has been repeatedly negligent in maintaining the offices where respondent cares for and treats patients,** by reason of the following:

a. The facts and allegations set forth in paragraphs 46 through 52 above are incorporated here as if fully set forth here.

ELEVENTH CAUSE OF ACTION
Failure to follow infection control guidelines.
REPEATED NEGLIGENCE

54. Respondent is subject to disciplinary action pursuant to sections 2234(c) of the Business and Professions Code 18 in that **he has been grossly negligent in maintaining the offices where respondent cares for and treats patients,** by reason of the following:

a. The facts and allegations set forth in paragraphs 46 through 52 above are incorporated here as if fully set forth here.

TWELFTH CAUSE OF ACTION
Failure to follow infection control guidelines.
INCOMPETENCE

55. Respondent is subject to disciplinary action pursuant to sections 2234(c) of the Business and Professions Code in that **he has been incompetent in maintaining the offices where respondent cares for and treats patients,** by reason of the following:

a. The facts and allegations set forth in paragraphs 46 through 52 above are incorporated here as if fully set forth here.

THIRTEENTH CAUSE OF ACTION
Acts Involving Dishonesty or Corruption

56. Respondent is subject to disciplinary action pursuant to section 2234(e) of the Business and Professions Code in that **he has committed acts involving dishonesty or corruption which are substantially related to the qualifications, functions or duties of a physician and surgeon,** by reason of the following: *[sic—nothing followed]*

57. On or about June 3, 1994 respondent applied for fictitious name permits pursuant to section 2415 of the Business and Professions Code to permit Midland Medical Center, Inc., to use the names "Family Planning Medical Clinic - El Monte," "Family Planning Center, L.A. West Side" and "Family Planning Center - Culver City" for the practice of medicine by respondent at 10958 Ramona Boulevard, El Monte, California; 5443 W. Washington Boulevard, Los Angeles, California; and 10826 Venice Boulevard, Culver City, California, respectively. Respondent listed as applicant(s) and shareholders on each application himself, Dolores Scott, M.D., and Jonathan Lee, M.D. Respondent declared under penalty of perjury under the laws of the state of California that all information on the applications was true and correct.

58. On June 3, 1994, pursuant to the applications described in paragraph 57 above, respondent was issued fictitious name permits numbers 21782, 21783 and 21784 for the Los Angeles, Culver City and El Monte office facilities, respectively, as more fullydescribe in paragraph 57 above.

59. Contrary to respondent's assertions under penalty of perjury described in paragraph 57 above, Dolores Scott, M.D., is not a shareholder in Midland Medical Clinic, Inc. Dolores Scott, M.D., does not have, and has not had in 1994, any professional or business relationship with respondent and/or Midland Medical Clinic, Inc.

60. Contrary to respondent's assertions under penalty of perjury described in paragraph 57 above, Jonathan Lee, M.D., is not a shareholder in Midland Medical Clinic, Inc. Jonathan Lee, M.D., does not have, and has never had, any professional or business relationship with respondent and/or Midland Medical Clinic, Inc.

61. Respondent's listing, on the June 3, 1994 Applications for a Fictitious Name Permit, described in paragraph 57 above, of Dolores Scott, M.D., and Jonathan Lee, M.D., as applicants and/or shareholders in Midland Medical Clinic, Inc., was false.

62. Falsely listing as shareholders and/or applicants physicians and surgeons who in fact have no business association with respondent or his corporation constitutes an act of dishonesty and/or corruption substantially related to the qualifications, functions or duties of a physician and surgeon.

THIRTEENTH CAUSE OF ACTION
False representation of Facts

63. Respondent is subject to disciplinary action pursuant to section 2261 of the Business and Professions Code in that he knowingly made or signed a certificate or document relating directly to the practice of medicine which falsely represented the existence or nonexistence of a state of facts, as more fully set forth below:

a. The facts and allegations set forth in paragraphs 57 through 62 above are incorporated here as if fully set forth here.

FOURTEENTH CAUSE OF ACTION
Quality of Care - Patient "J.C."

GROSS NEGLIGENCE

64. Respondent undertook the care and treatment of patient "J.C." on or about July 3, 1993. On or about July 3, 1993 patient "J.C." contacted respondent's clinic at 5443 West Washington Boulevard, Los Angeles, California. Patient "J.C." advised the clinic that she had tested positive for pregnancy with a home testing kit and desired to terminate the pregnancy. Patient "J.C." was given an appointment for July 17, 1993 at respondent's West Washington Boulevard office. Patient "J.C." went to respondent's clinic per her appointment on July 17, 1993, where Respondent performed a medical procedure terminating her pregnancy.

65. Respondent is subject to disciplinary action pursuant to section 2234(b) of the Business and Professions Code in that he has been grossly negligent in the care and treatment of patient "J.C.," by reason of the following:

a. The facts and allegations in paragraph 64 are incorporated here as if fully set forth here.

b. On or about July 3, 1993, respondent failed to schedule patient "J.C." for an appointment as soon as possible after her initial contact with his clinic, instead scheduling the appointment two weeks later.

c. On or about July 17, 1993, respondent failed to inform patient "J.C." that there would be a delay in seeing her and how much of a delay there would be. Respondent failed to return patient "J.C.'s" money when she requested a refund and attempted to leave because of the delay.

d. On or about July 17, 1993, respondent failed to obtain an accurate history of drug allergies from patient "J.C."

e. On or about July 17, 1993, respondent failed to perform a pregnancy test on patient "J.C." before initiating a medical procedure to terminate pregnancy.

f. On or about July 17, 1993 respondent failed to perform a blood test to determine the Rh status of patient "J.C.'s" blood.

g. On or about July 17, 1993 respondent performed a D & C procedure without first treating patient "J.C." for acute vaginitis and cervicitis.

h. On and after July 17, 1993 respondent failed to culture or otherwise follow-up on patient "J.C." foe acute vaginitis and cervicitis.

i. On or after July 17, 1993, respondent failed to perform or have performed a microscopic examination of the products of conception from the D & C procedure performed on patient "J.C.

FIFTEENTH CAUSE OF ACTION
Quality of Care - Patient "J.C."
REPEATED NEGLIGENCE

66. Respondent is subject to disciplinary action pursuant to sections 2234(c) of the Business and Professions Code in that **he has been repeatedly negligent in maintaining the offices where respondent cares for and treats patients,** by reason 26 of the following:

a. The facts and allegations set forth in paragraphs 64 and 65 above are incorporated here as if fully set forth here.

SIXTEENTH CAUSE OF ACTION
Quality of Care - Patient "J.C."
INCOMPETENCE

67. Respondent is subject to disciplinary action pursuant to sections 2234(c) of the Business and Professions Code in that **he has been incompetent in maintaining the offices where respondent cares for and treats patients**, by reason of the following:

a. The facts and allegations set forth in paragraphs 64 and 65 above are incorporated here as if fully set forth here.

SEVENTEENTH CAUSE OF ACTION
Quality of Care - Patient "J.L."
GROSS NEGLIGENCE

68. Respondent undertook the care and treatment of patient "J.L." on or about August 23, 1993. On or about August 23, 1993, patient "J.L." contacted respondent's clinic and arranged an appointment for the next day for a termination of pregnancy in the second trimester. Patient "J.L." was quoted a price of $350.00 for the procedure. On or about August 23, 1993, patient "J.L." went to respondent's clinic where she advised respondent that other clinics had declined to treat her because of a heart condition. Respondent advised the patient to answer all the questions on his health questionnaire in the negative so he would have no problems with paperwork. Respondent then performed an ultrasound examination, gave patient "J.L." laminaria to dilate her and advised her to return the next day. On August 24, 1994 patient "J.L." returned to respondent's clinic and was advised by respondent to return the next day since she was not dilated enough. On August 25, 1994 patient "J.L." returned to respondent's clinic and respondent performed the termination of pregnancy procedure. Respondent billed patient "J.L.'s" mother's American Express Card for $3,150.00.

69. Respondent is subject to disciplinary action pursuant to section 2234(b) of the Business and Professions Code in that he has been grossly negligent in the care and treatment of patient "J.L.," by reason of the following:

a. The facts and allegations in paragraph 68 are incorporated here as if fully set forth here.

b. On or about August 23, 1993, respondent failed to fully discuss and explain with patient "J.L." the cost of the procedure and to reduce the agreement on cost to writing.

c. On or about August 23, 1993, respondent failed to record the presence of cardiac disease in patient "J.L."

d. On or about August 23, 1993, respondent failed to refer patient "J.L." to a cardiac specialist for medical clearance before surgery.

e. On or about August 25, 1993, prior to initiating a medical procedure, respondent failed to prophylactically treat patient "J.L." with antibiotics due to her pre-existing heart condition.

f. On or about August 25, 1993, prior to initiating a medical procedure, respondent failed to ascertain whether patient "J.L." was taking any blood thinning medications.

g. On or about August 25, 1993 respondent failed to perform a blood test to determine the Rh status of patient "J.L.'s" blood.

h. On or about August 25, 1993, respondent failed to perform the surgery on patient "J.L." in a surgical suite with continuous cardiac monitoring by an anesthesiologist and with equipment and personnel to deal with any complications that could arise.

i. On or about August 25, 1993 respondent failed to administer appropriate hormones to patient "J.L." prior to intiating a medical procedure in order to limit bleeding during the procedure.

j. On or about August 25, 1993, respondent failed to use specialized instruments to facilitate evacuation of the uterus of patient "J.L." prior to initiating a medical procedure in order to the procedure.

k. On or about August 25, 1993, and thereafter, respondent failed to make a proper record of the surgical procedure performed on patient "J.L."

EIGHTEENTH CAUSE OF ACTION
Quality of Care - Patient "J.L."
REPEATED NEGLIGENCE

70. Respondent is subject to disciplinary action pursuant to sections 2234(c) of the Business and Professions Code in that **he has been repeatedly negligent in maintaining the offices where respondent cares for and treats patients,** by reason of the following:

a. The facts and allegations set forth in paragraphs 68 and 69 above are incorporated here as if fully set forth here.

NINETEENTH CAUSE OF ACTION
Quality of Care - Patient "J.L."
INCOMPETENCE

71. Respondent is subject to disciplinary action pursuant to sections 2234(c) of the Business and Professions Code in that **he has been incompetent in maintaining the offices where respondent cares for and treats patients,** by reason of the following:

a. The facts and allegations set forth in paragraphs 68 and 69 above are incorporated here as if fully set forth here.

Excerpt from Accusation dated 2/28/1995:

FIRST CAUSE OF ACTION
(Gross Negligence)

4. Respondent Lawson Alozie Akpulonu, M.D. is subject to disciplinary action under section 2234(b) of the Business and Professions Code in that he was grossly negligent in the care and treatment of patient A.A. The circumstances are as follows:

A. On or about January 28, 1995, patient A.A. went to the Midland Medical Center, located at 10826 Venice Boulevard, Culver City, Ca 90230, where respondent was employed. **While under anesthesia, following an abortion procedure that respondent performed on her, patient A.A. awoke to find respondent raping her; he had penetrated her vagina with his penis. Respondent gave patient A.A. a shot and she went back to sleep. When patient A.A. woke up a second time, she saw respondent next to her. She saw his erect penis out of his pants. She tried to push him away. She felt his erect penis when she pushed him away. Respondent then gave her another shot and she went back to sleep. When patient A.A. awoke for a third time, she found her sweater had been removed and her bra partially pulled down exposing her right breast. Respondent was caressing patient A.A.'s body. At one point, when patient A.A. tried to scream, respondent placed his hand over her mouth. Respondent told patient A.A. she had a beautiful body. He said she was a very nice girl and a very sexy girl while he continued rubbing her inside her blouse and bra. He kissed her right breast. He then placed his business card inside her bra and said she could call him anytime.**

B. Respondent's touching and fondling of patient A.A. and penetration of her with his penis on January 28, 1995 was an extreme departure from the standard of care and constituted gross negligence.

C. Respondent's statements to A.A. on January 28, 1995 that she was a very sexy girl and that she could call him anytime were, under the circumstances, extreme departures from the standard of care and constituted gross negligence.

D. Respondent's exposing of his penis to patient A.A. on January 28, 1995 was an extreme departure from the standard of care and represented gross negligence.

E. Respondent's failure to have a chaperon *[sic]* present for the procedure on patient A.A. on January 28, 1995 was an extreme departure from the standard of care and represented gross negligence.

F. The number of injections given by respondent to patient A.A. for the procedure on January 28, 1995 and the length of the procedure were grossly out of proportion to the norm and represent an extreme departure from the standard of care.

5. Respondent Lawson Alozie Akpulonu, M.D. is subject to disciplinary action under section 2234(b) of the Business and Professions Code in that h**e was grossly negligent in the care and treatment of patient T.O.** The circumstances are as follows:

A. On or about November 9, 1992, patient T.O. went to the clinic of Lawson Akpulonu, M.D. for a therapeutic abortion. The clinic was located at 9236 Long Beach Blvd., South Gate, California. When she was in the operating room at the clinic, respondent gave her a shot that was supposed to put her to sleep during the operation. She was very drowsy but never fell asleep. **After respondent gave her the shot, he ordered the nurse who was present to leave the room. Respondent then performed the operation. Immediately after the abortion, respondent began to massage patient T.O.'s vagina with his hand. Patient T.O. began to cry. Respondent also began to rub her thighs and buttocks and he fondled her breasts through her blouse. While respondent was touching her breasts, she could feel him rub his groin up against her exposed vagina. He had his pants on at the time. Patient T.O. continued to cry. She asked respondent what he was doing and pushed his hand away. Respondent then left the room and patient T.O. did not see him again. A short time later the nurse came back into the room and gave the patient some follow-up instructions. She then put her pants on and left the clinic with the person who had brought her.**

B. Conducting the termination procedure on or about November 9, 1992, under anesthesia without a chaperon present was an extreme departure from the standard of care by respondent and constituted gross negligence.

C. Respondent's fondling of patient T.O's breasts and touching her vagina and other parts of her body and his rubbing his crotch against patient T.O.'s exposed vagina on or about November 9, 1992, were extreme departures from the standard of care and constituted gross negligence.

6. Respondent Lawson Alozie Akpulonu, M.D. is subject to disciplinary action under section 2234(b) of the Business and Professions Code in that he was grossly negligent in the care and treatment of patient D.L. The circumstances are as follows:

A. On or about June 22, 1994 patient D.L. first went to see Dr. Lawson Akpulonu at his Culver City clinic for a termination of pregnancy. At the two week follow-up appointment on July 7, 1994 at a different clinic of respondent, she was told by respondent that she had HPV (human papilloma virus). On July 14, 1994 patient D.L. went to the Washington Blvd. clinic of respondent and he performed a colposcopy exam on her. During the examination, the phone rang and the respondent told his assistant to answer the phone, leaving her alone with the respondent for the rest of the examination. After the exam, patient D.L. met with respondent in his office to discuss the results. He told her that her infection was very severe and that it would cost $1500.00 for laser treatments. She began to cry when she learned the cost. He said what she had was treatable and that was more important than the money. **He also said, "Don't worry, I like you, I'll do anything for you." On or about July 22, 1994 patient D.L. went to respondent for the laser treatment. When she was in the examination room with respondent and the nurse at the beginning of the procedure before she was put to sleep, respondent told the nurse to leave and get something. The nurse then left the room. Patient D.L. went to sleep after that. The procedure lasted an hour and a half. Patient D.L. does not know if the nurse was present during the procedure. On Tuesday, August 2, 1994, patient D.L. had her fifth visit with respondent. When she arrived at the clinic, the respondent, who was consulting with another patient, came to take her blood himself. The nurse returned to the front desk. He put his right hand on patient D.L.'s left shoulder and firmly squeezed it. He then proceeded with the blood test. He wrapped a latex rubber glove around her arm. He had apparently run out of tourniquets. As the glove was tightened around her arm, two fingers of the glove blew into shape. Patient D.L. tapped the two fingers humorously. Then respondent tapped the fingers referring to them as penises by saying, "This one's Chinese, and this one's Vietnamese." After he made this comment, respondent closed the door. The nurse who was down the hall could no longer see them. He then finished the blood test. After respondent finished the blood test, patient D.L. got up to walk out the door. As she reached for the door knob, respondent from behind her put both of his hands firmly on her waist and pulled her back close towards him. She was confused. She turned her head and saw him smiling. She said "No" and freed herself from his hold and opened the door. A short time later she confronted him and said, "I didn't like what happened in the hallway. It shouldn't have happened. You crossed that line of trust between patient and doctor." He then replied, "What are you talking about?" She said, "You know exactly what happened. You grabbed me by the waist and pulled me close to you." He said, "Is that what this is all about? I'm sorry if you confused my holding your shoulders for your waist." Patient D.L. subsequently left the clinic.**

B. The statement of respondent that he liked the patient and would do anything for the patient represented an extreme departure from the standard of care since it was made with a sexual innuendo.

C. Respondent's examination of the patient on July 14, 1994 without a chaperon *[sic]* present was an extreme departure from the standard of care and constituted gross negligence.

D. Respondent's drawing blood from the patient on August 2, 1994 without a chaperon *[sic]* present was an extreme departure from the standard of care and constituted gross negligence.

E. Respondent's statement on August 2, 1994 to patient D.L. comparing an inflated glove's digits to penises was an extreme departure from the standard of care and represented gross negligence.

F. Respondent's squeezing of patient D.L.'s shoulder and later pulling her against him, both occurring on August 2, 1994, were extreme departures from the standard of care and constituted gross negligence.

SECOND CAUSE OF ACTION

(Sexual Misconduct)

7. Respondent Lawson Alozie Akpulonu, M.D. is subject to disciplinary action under section 726 of the Business and Professions Code in that he engaged in sexual misconduct with, sexual abuse of, and/or sexual relations with patient A.A. The 20 circumstances are as follows:

A. The facts and allegations set forth in paragraph 4 above are incorporated here as if fully set forth here.

8. Respondent Lawson Alozie Akpulonu, M.D. is subject to disciplinary action under section 726 of the Business and Professions Code in that he engaged in sexual misconduct with and/or sexual abuse of patient T.O. The circumstances are as follows:

A. The facts and allegations set forth in paragraph 5 above are incorporated here as if fully set forth here.

9. Respondent Lawson Alozie Akpulonu, M.D. is subject to disciplinary action under section 726 of the Business and Professions Code in that he engaged in sexual misconduct with and/or sexual abuse of patient D.L. The circumstances are as follows:

A. The facts and allegations set forth in paragraph 6 above are incorporated here as if fully set forth here.

THIRD CAUSE OF ACTION
(Repeated Negligent Acts)

10. Respondent Lawson Alozie Akpulonu, M.D. is subject to disciplinary action under section 2234(c) of the Business and Professions Code in that he engaged in repeated acts of negligence in the care and treatment of patient A.A. The circumstances are as follows:

A. The facts and allegations set forth in paragraph 5 above are incorporated here as if fully set forth here.

11. Respondent Lawson Alozie Akpulonu, M.D. is subject to disciplinary action under section 2234(c) of the Business and Professions Code in that he engaged in repeated acts of negligence in the care and treatment of patient T.O. The circumstances are as follows:

A. The facts and allegations set forth in paragraph 5 above are incorporated here as if fully set forth here.

12. Respondent Lawson Alozie Akpulonu, M.D. is subject to disciplinary action under section 2234(c) of the Business and Professions Code in that he engaged in repeated acts of negligence in the care and treatment of patient D.L. The circumstances are as follows:

A. The facts and allegations set forth in paragraph 6 above are incorporated here as if fully set forth here.

Make a note of the doctor's license number, then click here to go to the Medical Board of California lookup page.

This Record was entered on: 05/12/2018 This Record was modified on: 06/30/2018

This website came about when it was discovered that the Medical Board of California's website was very flawed and missing a startling amount of Public disciplinary information. When we tried to work with the board (at the time, Executive Director Kimberly Kirchmeyer and Staff Attorney Kerrie Webb), they chose to not participate and made it very difficult to get the public information we were requesting, which they still do to this day. It was due to their inaction and beligerance that this website was created. Anyone having a problem with this website's existence or the information it contains, should direct their criticism to the Medical Board of California by clicking their names to send an email to them.

DISCLAIMER: Most of the information found on this website is hand-culled directly from the Medical Board of California's ("Board") website and from news articles and is only as good as that original information; it's just easier to find and read here. We have a VERY small team of advocates working on this project, and cannot keep everything up to date in real time. **Always check the Medical Board website directly for more information or changes.**

Infractions are pulled from the "Board's" disciplinary documents themselves and/or news articles. Sometimes the categories here don't match the Medical Board's categories exactly, so make sure you look up the infractions in the actual Medical Board documents.

Note: "Accusations" mean that a doctor has not had a hearing or been found guilty of any charges, but are being investigated by the Medical Board and/or the California Attorney General's Office.

****The California Medical Association (CMA) is a union of sorts for doctors in California. They have a lot of political power and donate a lot of money to the state's legislators in return for their "support." They appear to have a lot of "sway" over the Medical Board's members. One would think that most doctors would be members of the CMA with the amount of power they wield, but in actuality, 2/3 of this state's doctors refuse to join the CMA...which means that the majority of doctors in the state, choose to NOT be members.**

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