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Attorneys for Complainant

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

In the Matter of the Accusation Against:

LAWSON AKPULONU, M.D.
5443 W. Washington Blvd.
Los Angeles, CA 90016

Physician's and Surgeon's Certificate No. A31917

Respondent.

No. D-5286

OAH. No. L-63123

DEFAULT DECISION

[Gov. Code §11520]

FINDINGS OF FACT

1. On or about July 2, 1993, Complainant Dixon Arnett, in his official capacity as Executive Director of the Medical Board of California, Department of Consumer Affairs, State of California ("Board"), filed Accusation No. D-5286 against Lawson Akpulonu, M.D. ("respondent").

2. On or about August 6, 1993, an employee of the Board, sent by certified mail a copy of Accusation No. D-5286, Statement to Respondent, Government Code sections 11507.5, 11507.6, and 11507.7, the Notice of Defense form, and a Request for Discovery,

to respondent's address of record with the Board which was and is 5443 W. Washington Blvd., Los Angeles, CA 90016. On or about August 9, 1993, the signed domestic return receipt for the above certified mail packet was returned by the U.S. Postal Service. The above described service was effective as a matter of law pursuant to the provisions of California Government Code section 11505, subdivision (c). A copy of the Accusation, the pleading packet, Declaration of Service and postal returned receipts are attached hereto as "**Appendix A**," and they are incorporated as if fully set forth herein.

3. On or about August 12, 1993, Complainant in his official capacity as Executive Director of the Board filed an Amended and Supplemental Accusation in Case No. D-5286.

4. On or about August 12, 1993, Francene Bolden, an employee of the Office of the Attorney General, sent by certified mail a copy of the Amended and Supplemental Accusation in Case No. D-5286 along with a Statement to Respondent to respondent's address of record. On or about August 17, 1993 the signed domestic return receipt for the above certified mail was returned by the U.S. Postal Service. The above described service was effective as a matter of law pursuant to the provisions of the California Government Code, section 11505, subdivision (c). A copy of the Supplemental Accusation, the Supplemental Statement to Respondent, Declaration of Service, and postal returned receipts are attached hereto as "**Appendix B**," and they are incorporated as if fully set forth herein.

5. On or about December 7, 1994, Complainant in his

official capacity as Executive Officer of the Board, filed a Second Amended and Supplemental Accusation in Case No. D-5286 against respondent.

6. On or about December 7, 1994 the Second Amended and Supplemental Accusation in Case No. D-5286, along with a Supplemental Statement to Respondent, was sent by Tom Buck, an employee of the Office of the Attorney General, by certified mail to the respondent at his address of record. On or about December 8, 1994, the signed domestic return receipt for the above certified mail packet was returned by the U.S. Postal Service. The above-described service was effective as a matter of law pursuant to provisions of California Government Code, section 11505, subdivision (c). A copy of the Second Amended and Supplemental Accusation, the Supplemental Statement to Respondent, Declaration of Service, and postal returned receipts are attached hereto as "**Appendix C**," and they are incorporated as if fully set forth herein.

7. On or about May 23, 1996, a Notice of Hearing was served by regular mail on respondent at his address of record, setting a hearing for August 5, 1996, at 9:00 a.m. at the Office of Administrative Hearings, California State Office Building, 314 West First Street, Los Angeles, California. A copy of the Notice of Hearing and Declaration of Service are attached hereto as "**Appendix D**," and are incorporated as if fully set forth herein.

8. On August 5, 1996, respondent failed to appear at the hearing referred to in paragraph 7 above. See the Declaration of Deputy Attorney General E. A. Jones, III, attached hereto as

"**Appendix E**," and incorporated as if fully set forth herein.

9. On February 16, 1978, the Medical Board of California issued Physician's and Surgeon's Certificate No. A-31917 to respondent. Respondent's license was suspended pursuant to Government Code section 11529 on or about February 17, 1995. On or about April 30, 1995, respondent's certificate expired. A certificate of licensure is attached hereto as "**Appendix F**," and is incorporated as if fully set forth herein.

10. California Business and Professions Code section 118 provides, in pertinent part:

> "(b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the license on any such ground."

11. California Government Code section 11506 provides, in pertinent part:

> "(b) The respondent shall be entitled to a hearing on the merits if he files a notice of defense, and any such notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file such

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

12. Respondent failed to failed to appear at the noticed hearing on the Accusation and therefore waived his right to a hearing on the merits of the Accusation, Amended and Supplemental Accusation and Second Amended and Supplemental Accusation in Case No. D-5286.

13. California Government Code section 11520 provides, in pertinent part:

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

14. The Division of Medical Quality, Medical Board of California, Department of Consumer Affairs, is authorized to revoke respondent's Physician's and Surgeon's Certificate pursuant to the following provisions of the California Business and Professions Code:

a. Section 2227 provides that the Board may revoke, suspend for a period not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act.

b. Section 2234 provides that unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or

indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts.

(d) Incompetence.

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

(f) Any action or conduct which would have warranted the denial of a certificate."

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

15. Pursuant to its authority under Government Code section 11520, the Division will take action without further hearing and, based on the respondent's admissions by way of default and the evidence before it, as contained in **Appendix G**, finds that the allegations, and each of them, contained in the Accusation, Amended and Supplemental Accusation and Second Amended and Supplemental Accusation in Case No. 17-95-46707 are true.

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DETERMINATION OF ISSUES

1. Respondent is subject to disciplinary action pursuant to section 2227 of the California Business and Professions Code by reason of the Finding of Facts numbers 1 through 15, above.

ORDER OF THE DIVISION

Physician's and Surgeon's Certificate number A31917, heretofore issued to respondent Lawson Akpulonu, M.D., is hereby revoked. An effective date of October 11, 1996, has been assigned to this Order.

Pursuant to California Government Code section 11520, subdivision (b), respondent is entitled to make any showing by way of mitigation; however, such showing must be made in writing to the Medical Board of California, 1426 Howe Avenue, Suite 100, Sacramento, CA 95825-3236, prior to the effective date of this decision.

Made this 11th day of September, 1996.

FOR THE DIVISION

Attachments: Appendices A through G

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Attorneys for Complainant

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

In the Matter of the Accusation Against: Lawson A. Akpulonu, M.D. P.O. Box 19908 Los Angeles, CA 90019 Physician and Surgeon's License No. A-31917, Respondent.	NO. D-5286 A C C U S A T I O N

The Complainant alleges:

PARTIES

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

2. On or about February 16, 1978, Certificate No. A-31917 was issued by the Board to Lawson A. Akpulonu (the "respondent"), and at all times relevant to the charges brought here, the certificate has been in full force and effect. The certificate is paid and current with an expiration date of April

30, 1993.

JURISDICTION

3. This accusation is brought under the authority of the following sections of the California Business and Professions Code:

4. Pursuant to sections 2004 and 2220 of the Business and Professions Code, the Division of Medical Quality (the "Division") of the Board has authority to enforce and administer the disciplinary provisions of the Medical Practice Act (Bus. & Prof. Code Sections 2000, *et seq.*) as they apply to physicians and surgeons.

5. Pursuant to Business and Professions Code section 2234, the Division shall take disciplinary action against any physician and surgeon who has engaged in unprofessional conduct. The section defines unprofessional conduct to include the commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions or duties of a physician and surgeon [subsection (e)].

6. Section 490 of the Business and Professions Code provides as follows:

> A board may suspend or revoke a license on the ground that the licensee has been convicted of a crime, if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued....A conviction within the meaning of this section means a plea or verdict of guilty or a conviction following a plea of nolo

1 contendere. Any action which a board is permitted to
2 take following the establishment of a conviction may be
3 taken when the time for appeal has elapsed, or the
4 judgement of conviction has been affirmed on appeal, or
5 when an order granting probation is made suspending the
6 imposition of sentence, irrespective of a subsequent
7 order under the provisions of Section 1203.4 of the
8 Penal Code.

9 7. Business and Professions Code section 2236
10 provides as follows:

11 (a) The conviction of any offense substantially
12 related to the qualifications, functions, or duties of
13 a physician and surgeon constitutes unprofessional
14 conduct within the meaning of this chapter. The record
15 of conviction shall be conclusive evidence only of the
16 fact that the conviction occurred.

17 (b) The Division may inquire into the circumstances
18 surrounding the commission of the crime in order to fix
19 the degree of discipline or to determine if such
20 conviction is of an offense substantially related to
21 the qualifications, functions, or duties of a physician
22 and surgeon. A plea or verdict of guilty or a
23 conviction following a plea of nolo contendere made to
24 a charge substantially related to the qualifications,
25 functions, or duties of a physician and surgeon is
26 deemed to be a conviction within the meaning of this
27 section.

(c) Discipline may be ordered in accordance with Section 2227, or the Division of Licensing may order the denial of the license when the time for appeal has elapsed, or the judgement of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information or indictment.

8. Business and Professions Code section 2261 provides as follows:

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

9. Business and Professions Code section 2262 provides as follows:

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

In addition to any other disciplinary action, the Division of Medical Quality or the California Board of

Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section.

10. Business and Professions Code section 810 provides as follows:

"(a) It shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his professional activities:

(1) Knowingly present or cause to be presented any false or fraudulent claim for payment of a loss under a contract of insurance.

(2) Knowingly prepare, make, or subscribe any writing, with intent to present or use the same, or allow it to be presented or used in support of any such claim.

(b) As used in this section, health care professional means any person licensed or certified pursuant to this division, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act."

FIRST CAUSE OF ACTION

11. Respondent is subject to disciplinary action under Business and Professions Code sections 2234(e), 2261, 2262 and 810(a)(1), as more fully set forth below:

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." 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 11(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 810(a)(1), 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):

(1) M.A. January 19, 1990

(2) V.A. August 8, 1990

(3) G.A. April 9, 1990

(4)	K.A.	January 23, 1990
(5)	S.A.	November 10, 1989
(6)	V.B.	November 30, 1989
(7)	D.B.	April 3, 1990
(8)	D.B.	November 29, 1989
(9)	J.B.	March 1, 1990
(10)	D.B.	November 4, 1989
(11)	P.B.	December 8, 1989
(12)	C.C.	April 9, 1990
(13)	G.C.	May 11, 1990
(14)	T.C.	October 25, 1989
(15)	K.C.	March 15, 1990
(16)	C.C.	November 3, 1989
(17)	T.D.	October 24, 1989
(18)	D.D.	October 27, 1989
(19)	D.D.	May 11, 1990
(20)	L.D.	March 9, 1990
(21)	R.E.	April 10, 1990
(22)	A.E.	May 2, 1990
(23)	J.F.	December 8, 1989
(24)	A.G.	May 1, 1990
(25)	F.G.	November 10, 1989
	F.G.	April 5, 1990
(26)	L.G.	December 5, 1989
(27)	M.G.	February 21, 1990
(28)	N.G.	February 17, 1990
(29)	R.H.	April 14, 1990

1 (30) A.H. March 5, 1990
2 (31) J.H. December 4, 1989
3 (32) C.J. January 5, 1990
4 (33) M.K. April 18, 1990
5 (34) S.L. April 13, 1990
6 (35) S.L. November 13, 1990
7 (36) R.L. April 13, 1990
8 (37) A.L. May 9, 1990
9 (38) K.M. December 22, 1989
10 (39) M.M. November 13, 1989
11 (40) V.M. November 3, 1989
12 (41) R.N. January 13, 1990
13 (42) D.P. November 13, 1989
14 (43) S.P. November 18, 1989
15 (44) R.P. July, 13, 1990
16 (45) E.P. November 20, 1989
17 (46) V.P. April 9, 1990
18 (47) D.R. March 7, 1990
19 (48) L.R. August 26, 1989
20 (49) L.R. January 3, 1990
21 (50) G.S. April 3, 1990
22 (51) D.S. August 1, 1990
23 (52) C.S. April 18, 1990
24 (53) V.T. December 7, 1989
25 (54) S.T. May 1, 1990
26 (55) L.T. November 29, 1989
27 (56) A.T. November 30, 1989

(57) B.W. December 2, 1989

(58) L.W. March 2, 1990

(59) C.W. November 9, 1989

(60) J.W. May 15, 1990

(61) C.Y. December 11, 1990

(62) J.Y. March 18, 1990

THIRD CAUSE OF ACTION

13. Respondent is subject to disciplinary action under Business and Professions Code sections 2234(e), 2261, 2262 and 810(a)(1), 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:

(1) M.A. January 19, 1990

(2) G.A. April 9, 1990

(3) K.A. January 23, 1990

(4) S.A. November 10, 1989

(5) L.B. July 18, 1989

(6) A.B. October 6, 1989

(7) D.B. June 26, 1989

(8) V.B. November 30, 1989

(9) B.B. July 24, 1989

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Attorneys for Complainant

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

In the Matter of the Accusation Against: Lawson A. Akpulonu, M.D. P.O. Box 19908 Los Angeles, CA 90019 Physician and Surgeon's License No. A-31917, Respondent.	NO. D-5286 AMENDED AND SUPPLEMENTAL ACCUSATION

The Complainant alleges:

PARTIES

27. Complainant, Dixon Arnett is the Executive Director of the Medical Board of California (the "Board") and brings this Amended and Supplemental Accusation solely in his official capacity.

28. On or about February 16, 1978, License No. A-31917 was issued by the Board to Lawson A. Akpulonu (the "respondent"), and at all times relevant to the charges brought here, the license has been in full force and effect. The license

has an expiration date of April 30, 1993. On or about July 2, 1993, an Accusation was filed in Case No. D-5286 (this Accusation is incorporated by reference as though fully set forth here). A copy of the Accusation, Statement to Respondent, Government Code sections 11507.5, 11507.6, and 11507.7, Notice of Defense and Request for Discovery were served upon respondent on July 2, 1993 by certified mail. No hearing on the Accusation has been held.

JURISDICTION

29. This Amended and Supplemental Accusation, which adds to the charges already set forth in the original Accusation No. D-5286, filed July 2, 1993, is brought under the authority of the following sections of the California Business and Professions Code:

30. Pursuant to sections 2004 and 2220 of the Business and Professions Code the Division of Medical Quality (the "Division") of the Board has authority to enforce and administer the disciplinary provisions or the Medical Practice Act (Bus. & Prof. Code section 2000 *et seq.*) as they apply to physicians and surgeons. The Division may revoke, suspend, place on probation, publicly remand and take any other appropriate disciplinary action against a licensee pursuant to Section 2227 of the Business and Professions Code.

31. Pursuant to section 2234 of the Business and Professions Code, the Division shall take disciplinary action against any physician and surgeon who has engaged in unprofessional conduct. The section defines unprofessional conduct to include gross negligence (subdivision [b]); repeated

negligent acts (subdivision [c]); and incompetence (subdivision [d]). The section also defines unprofessional conduct to include the commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions or duties of a physician and surgeon [subsection (e)].

32. Section 11507 of the Government Code (the Administrative Procedure Act) provides that at any time before the matter is submitted for decision the agency may file or permit the filing of an Amended or Supplemental Accusation.

SEVENTH CAUSE OF ACTION

33. On or about November 2, 1990, respondent undertook the care and treatment of "G.B."[1], 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

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1. The patient will be fully identified during the course of discovery.

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.

PRAYER

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

1. Revoking or suspending License Number A-31917, previously issued by the Board to respondent Lawson A. Akpulonu, M.D.;

2. In addition to any other disciplinary action, imposing a civil penalty of five hundred dollars ($500) on respondent for each violation of Business and Professions Code section 2262, pursuant to Business and Professions Code section 2262.

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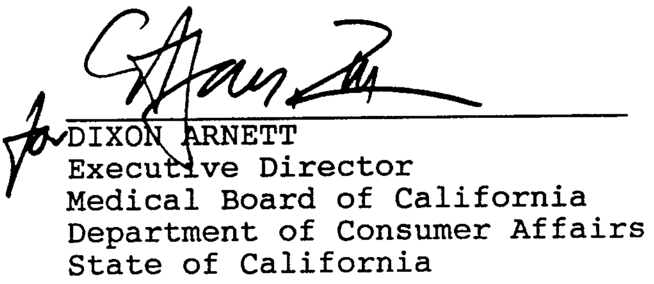
3. Taking such other and further action as the Board deems proper and appropriate.

DATED: 8/12/93.



for DIXON ARNETT
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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

In the Matter of the Accusation Against: Lawson A. Akpulonu, M.D. P.O. Box 19908 Los Angeles, CA 90019 Physician and Surgeon's License No. A-31917, Respondent.	NO. D-5286 OAH. No. L-63123 **SECOND AMENDED AND SUPPLEMENTAL ACCUSATION**

The Complainant alleges:

PARTIES

36. Complainant, Dixon Arnett is the Executive Director of the Medical Board of California (the "Board") and brings this Second Amended and Supplemental Accusation solely in his official capacity.

37. On or about February 16, 1978, License No. A-31917 was issued by the Board to Lawson A. Akpulonu (the "respondent"), and at all times relevant to the charges brought here, the license has been in full force and effect. The license

has an expiration date of April 30, 1993. On or about July 2, 1993, an Accusation was filed in Case No. D-5286 (this Accusation is incorporated by reference as though fully set forth here). A copy of the Accusation, Statement to Respondent, Government Code sections 11507.5, 11507.6, and 11507.7, Notice of Defense and Request for Discovery were served upon respondent on July 2, 1993 by certified mail. On or about August 12, 1993 an Amended and Supplemental Accusation was filed in Case No. D-5286 (this Amended and Supplemental Accusation is incorporated by reference as though fully set forth here). On or about August 12, 1993 the Amended and Supplemental Accusation and a Statement to Respondent were served upon respondent by certified mail. No hearing on the Accusation and the Amended and Supplemental Accusation has been held.

JURISDICTION

38. This Second Amended and Supplemental Accusation, which adds to the charges already set forth in the original Accusation No. D-5286, filed July 2, 1993, and in the Amended and Supplemental Accusation in Case No. D-5286 filed on August 12, 1993, is brought under the authority of the following sections of the California Business and Professions Code:

39. Pursuant to sections 2004 and 2220 of the Business and Professions Code the Division of Medical Quality (the "Division") of the Board has authority to enforce and administer the disciplinary provisions or the Medical Practice Act (Bus. & Prof. Code section 2000 *et seq.*) as they apply to physicians and surgeons. The Division may revoke, suspend, place on probation,

publicly remand and take any other appropriate disciplinary action against a licensee pursuant to Section 2227 of the Business and Professions Code.

40. Pursuant to section 2234 of the Business and Professions Code, the Division shall take disciplinary action against any physician and surgeon who has engaged in unprofessional conduct. The section defines unprofessional conduct to include gross negligence (subdivision [b]); repeated negligent acts (subdivision [c]); and incompetence (subdivision [d]). The section also defines unprofessional conduct to include the commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions or duties of a physician and surgeon [subsection (e)].

41. Section 11507 of the Government Code (the Administrative Procedure Act) provides that at any time before the matter is submitted for decision the agency may file or permit the filing of an Amended or Supplemental Accusation.

42. Section 2221.1 of the Business and Professions Code provides as follows:

"The board and the Board of Podiatric Medicine shall investigate and may take disciplinary action, including, but not limited to, revocation or suspension of licenses, against physicians and surgeons and all others licensed or regulated by the board, or by the Board of Podiatric Medicine, whichever is applicable, who, except for good cause, knowingly fail to protect patients by failing to follow infection control guidelines of the applicable board,

thereby risking transmission of blood-borne infectious diseases from the physician and surgeon or to the health care provider licensed or regulated by the applicable board to patients, from patients, and from patient to physician and surgeon or other health care provider regulated by the applicable board."

43. Business and Professions Code section 2261 provides as follows:

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

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

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 and 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

1 and fetal material less than five months old by
2 flushing it down the toilet.
3 b. Respondent kept the clinic in poor sanitary
4 condition.
5 c. Employees did not receive training in
6 universal precautions to prevent transmission of blood-
7 borne pathogens.
8 d. There was no posted exposure control plan or
9 list of jobs which involved exposure to blood-borne
10 pathogens.
11 e. Respondent did not have equipment or
12 examination rooms properly sterilized between
13 procedures.
14 f. Employees assisting in medical procedures
15 were not provided aprons, masks or hair covers.
16 g. Respondent reused items that should have been
17 disposed of after their initial use such as plastic
18 equipment inserted in patients' vaginas and tubing that
19 transported products of conception.
20 h. The clinic was dirty with no cleaning service
21 brought in to clean the clinic.
22 50. On or about September 16, 1993, the following
23 conditions were observed at respondent's Midland Medical Center
24 at 5443 West Washington Boulevard, Los Angeles, California:
25 a. The examination rooms had a bad smell about
26 them.
27 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 gloves 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

with 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. There was 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 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.

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 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.

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:

57. On or about June 3, 1994 respondent applied for fictitious name permits pursuant to section 2415 of the Business

1 and Professions Code to permit Midland Medical Center, Inc., to
2 use the names "Family Planning Medical Clinic - El Monte,"
3 "Family Planning Center, L.A. West Side" and "Family Planning
4 Center - Culver City" for the practice of medicine by respondent
5 at 10958 Ramona Boulevard, El Monte, California; 5443 W.
6 Washington Boulevard, Los Angeles, California; and 10826 Venice
7 Boulevard, Culver City, California, respectively. Respondent
8 listed as applicant(s) and shareholders on each application
9 himself, Dolores Scott, M.D., and Jonathan Lee, M.D. Respondent
10 declared under penalty of perjury under the laws of the state of
11 California that all information on the applications was true and
12 correct.

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

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

24 60. Contrary to respondent's assertions under penalty
25 of perjury described in paragraph 57 above, Jonathan Lee, M.D.,
26 is not a shareholder in Midland Medical Clinic, Inc. Jonathan
27 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." for 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 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

1 performed an ultrasound examination, gave patient "J.L."
2 laminaria to dilate her and advised her to return the next day.
3 On August 24, 1994 patient "J.L." returned to respondent's clinic
4 and was advised by respondent to return the next day since she
5 was not dilated enough. On August 25, 1994 patient "J.L."
6 returned to respondent's clinic and respondent performed the
7 termination of pregnancy procedure. Respondent billed patient
8 "J.L.'s" mother's American Express Card for $3,150.00.
9 69. Respondent is subject to disciplinary action
10 pursuant to section 2234(b) of the Business and Professions Code
11 in that he has been grossly negligent in the care and treatment
12 of patient "J.L.," by reason of the following:
13 a. The facts and allegations in paragraph 68 are
14 incorporated here as if fully set forth here.
15 b. On or about August 23, 1993, respondent
16 failed to fully discuss and explain with patient "J.L."
17 the cost of the procedure and to reduce the agreement
18 on cost to writing.
19 c. On or about August 23, 1993, respondent
20 failed to record the presence of cardiac disease in
21 patient "J.L."
22 d. On or about August 23, 1993, respondent
23 failed to refer patient "J.L." to a cardiac specialist
24 for medical clearance before surgery.
25 e. On or about August 25, 1993, prior to
26 initiating a medical procedure, respondent failed to
27 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 initiating 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."

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.

PRAYER

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

1. Revoking or suspending License Number A-31917, previously issued by the Board to respondent Lawson A. Akpulonu, M.D.;

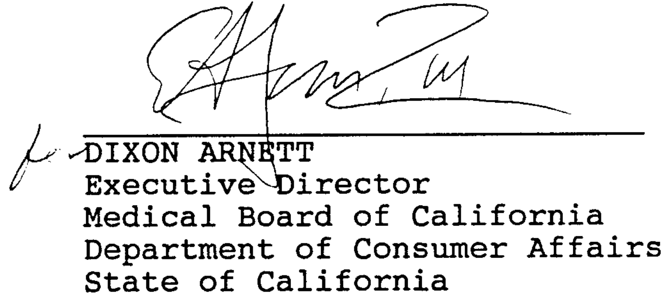
2. Directing respondent Lawson A. Akpulonu, M.D. to pay to the Board a reasonable sum for its investigative and

1 enforcement costs of this action; and

2 3. Taking such other and further action as the Board

3 deems proper and appropriate.

4 DATED: 12/7/94.



DIXON ARNETT
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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