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

In the Matter of the Accusation Against:	)	
	)	
	)	
SHIQUAN XIONG, M.D.	)	Case No. 08-2012-225501
	)	
Physician's and Surgeon's	)	
Certificate No. A 102651	)	
	)	
Respondent.	)	
	)	

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Medical Board of California, Department of Consumer Affairs, State of California, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on April 24, 2015.

IT IS SO ORDERED March 26, 2015.

MEDICAL BOARD OF CALIFORNIA

By: Dev Gnanadev MD
Dev Gnanadev, M.D., Chair
Panel B

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General
CHRIS LEONG
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **SHIQUAN XIONG, M.D.** **10201 Hinderhill Drive** **Bakersfield, CA 93312** **Physician's and Surgeon's Certificate No. A 102651** Respondent.	Case No. 08-2012-225501 OAH No. 2014060762 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California ("Board"), the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Board. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Chris Leong, Deputy Attorney General.

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2. Respondent SHIQUAN XIONG, M.D. ("Respondent") is represented in this proceeding by attorney Indra Lahiri, Esq. whose address is: 2001 22nd Street, Suite 110, Bakersfield, CA 93301.

3. On or about January 30, 2008, the Board issued Physician's and Surgeon's Certificate No. A 102651 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 08-2012-225501 and will expire on December 31, 2015, unless renewed.

JURISDICTION

4. Accusation No. 08-2012-225501 was filed before the l Board and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on May 15, 2014. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 08-2012-225501 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 08-2012-225501. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 08-2012-225501, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up her right to contest those charges.

11. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

12. Respondent agrees that if she ever petitions for early termination of probation or modification of probation, or if the board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 08-2012-225501, shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including Portable Document Format (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 102651 issued to Respondent SHIQUAN XIONG, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial

enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than one (1) year after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. PROFESSIONAL BOUNDARIES PROGRAM. Within 60 calendar days from the effective date of this Decision, Respondent shall enroll in a professional boundaries program equivalent to the Professional Boundaries Program offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine ("Program"). Respondent, at the Program's discretion, shall undergo and complete the Program's assessment of Respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24 hour program of interactive education and training in the area of

boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the Board or its designee deems relevant. The Program shall evaluate Respondent at the end of the training and the Program shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire Program not later than one (1) year after Respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. Based on Respondent's performance in and evaluations from the assessment, education, and training, the Program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that Respondent can practice medicine safely. Respondent shall comply with Program recommendations. At the completion of the Program, Respondent shall submit to a final evaluation. The Program shall provide the results of the evaluation to the Board or its designee. The professional boundaries program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

The Program has the authority to determine whether or not Respondent successfully completed the Program.

A professional boundaries course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

If Respondent fails to complete the Program within the designated time period, Respondent shall cease the practice of medicine within three (3) calendar days after being notified by the Board or its designee that Respondent failed to complete the Program.

6. CLINICAL TRAINING PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of

California - San Diego School of Medicine ("Program"). Respondent shall successfully complete the Program not later than one (1) year after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. Determination as to whether Respondent successfully completed the examination or successfully completed the program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program have been completed. If the Respondent did not successfully complete the clinical training program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of

the probationary time period.

Within 60 days after Respondent has successfully completed the clinical training program, Respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

7. MONITORING - PRACTICE/BILLING. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice and billing monitors, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice and billing shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the

premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of both, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

8. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision,

Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

9. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

10. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

11. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

12. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

13. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

14. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the

probation unit office, with or without prior notice throughout the term of probation.

15. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

16. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

17. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and

carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

18. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

19. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Indra Lahiri. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

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DATED: 1-12-15

SHIQUAN XIONG, M.D.
Respondent

I have read and fully discussed with Respondent SHIQUAN XIONG , M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 1/12/15

INDRA LAHIRI, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 1/12/15

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

CHRIS LEONG
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 08-2012-225501

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

In the Matter of the Accusation Against: **SHIQUAN XIONG, M.D.** 10201 Hinderhill Drive Bakersfield, CA 93312 Physician's and Surgeon's Certificate No. A 102651 Respondent.	Case No. 08-2012-225501 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant), brings this Accusation solely in her official capacity as Executive Director of the Medical Board of California (Board).

2. On or about January 30, 2008, the Board issued Physician's and Surgeon's Certificate Number A 102651 to Shiquan Xiong, M.D. (Respondent). This license was in full force and effect at all times relevant to the charges brought herein and expires on December 31, 2015, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states, in pertinent part:

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

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

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

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the Board.

"(4) Be publicly reprimanded by the Board.

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

5. Section 2234 of the Code, states:

"The Board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

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

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for

that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(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.

"...."

6. Section 2238 of the Code states:

"A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

7. Section 2242, subdivision (a) of the Code states: " Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct."

8. Section 2244 of the Code states:

"A physician and surgeon who collects biological specimens for clinical testing or examination shall secure or ensure that his or her employees, agents, or contractors secure those specimens in a locked container when those specimens are placed in a public location outside the custodial control of the licensee, or his or her employees, agents, or contractors, pursuant to the requirements of Section 681.

"Commencing after July 1, 2000, the board may impose a fine against a licensee not to exceed the sum of one thousand dollars ($1,000) for a violation of this section.

"This section shall not apply when the biological specimens have been received by mail in compliance with all applicable laws and regulations."

9. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

10. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

11. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that she was grossly negligent in the care and treatment of Patients T.T.[1] and R.S. and for her conduct regarding the Truxton Psychiatric Medical Group. The circumstances are as follows:

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[1] The names of the patients are reduced to initials for privacy.

Patient T.T.

12. Patient T.T., then 45 years of age, was treated twice by Respondent on, February 10, 2012, and June 29, 2012. Respondent recorded the visits on an electronic record in the Garden Oasis Medical Clinic. Initially, on February 10, 2012, T.T., who had a history of bipolar disorder, was recorded as seeking a "full psychiatric evaluation." Included in presenting symptoms were: hearing voices, insomnia for days, sexual indiscretions and buying sprees. She had had these symptoms for at least nine years. She had a prior history of illicit drug use, many inpatient psychiatric admissions, and prison stays. She had received from her recent prior psychiatrist Lexapro 10 mg, Depakote 1000 mg at bedtime, Seroquel 200 mg in the morning and 600 mg at bedtime, Ambien 10 mg at bedtime, Klonopin 0.5 mg twice a day and Tegretol 600 mg at bedtime. Respondent noted, "She stops taking her medication for a while." After further discussion of symptoms, history, mental status and physical examination, Respondent assessed that T.T. is suffering from "Axis I bipolar I disorder most recent episode (or current) manic severe specified with psychotic behavior and generalized anxiety disorder." She lists the Axis II diagnosis as "deferred, Axis III several musculoskeletal symptoms", "Axis IV severe" and "Axis V GAF 55." Respondent planned to order a complete blood count (CBC), thyroid stimulating hormone (TSH), urine toxicology screen and a basic metabolic profile. Concerning medication she planned to taper down the Tegretol and stop it; she was going to stop Ambien, renew klonopin 0.5 mg twice a day, and Seroquel only 200 mg every AM. Depakote was to continue at 1000 mg at bedtime. Respondent mentioned education concerning substances of abuse, attendance at 12 step programs, brief supportive psychotherapy and "pcp co-management, collateral information" and T.T. was to return in one week.

13. The next psychiatric visit of T.T. was June 29, 2012. She was with her boy friend, and complained of auditory and visual hallucinations and delusions of demons out to get her. At this point she mentioned she had a seizure disorder. She is also now taking Neurontin 300 mg, Depakote 100 mg at bedtime and Seroquel 200 mg in AM and 200 mg in the day as well. After repeating the same diagnosis, Axes I through IV as before, Respondent planned to: start Remoron 15 mg at bedtime, Klonopin 1 mg daily, Cogentin 0.5 mg twice a day, Haldol 3 mg divided; again

she stops Ambien, tapers down Tegretol, tapers down Seroquel to 400 mg daily, and reduced Lexapro to 5 mg daily. Respondent freely discussed substance abuse and brief supportive psychotherapy, personal construct psychology (PCP) co-management. She ordered T.T. back in one week and she billed for one hour of treatment.

14. Respondent's notes for both visits in the electronic record are chaotic, and at times contradictory and do not convey a reliable account of the patient's problems, history, presentation, or treatment. For example, the "HPI," or history of presenting illness, in February contains a jumble of past and present symptoms so that the reader is not sure when the symptoms occurred. This is compounded by additional headings for past psychiatric history, which contains information about her past and then jump to her current medication.

15. In the return visit of June 29, 2012, Respondent's records noted as follows:

A. Respondent starts by describing hallucinations and delusions the patient is experiencing, then jumps to the seizure disorder, then states "discussed with patient the liver impairment se (sic) from taking 2 med that cause liver impairment." Respondent recommended the patient see a primary care provider and referred her to a neurologist at least once for med management. She also recommended and discussed the side effects of Seroquel. This is a mix of presenting symptoms, past history, discussion and planning, all before the examination of the patient and under the heading "history of present illness."

B. Respondent's records are unclear. For example:

1) There are ambiguous and/or unclear statements such as "Thought Process: Linear but blocked."

2) "The patient has some illusions and auditory hallucinations not pertinent to her illicit drug use, about a few times every day." This statement also is used for other patients. This statement is unclear because it is unclear if she means the patient is using drugs, or is not using drugs. It is unclear because the note does not mention which drugs. Further, it is unclear what "not pertinent" means in this context.

3) Respondent uses an unclear phrase, "She is restless because she is a status of meeting a new doctor" (sic), in the mental status exam of T.T. in February. In

describing another patient, R.S., on June 22, 2012, she reports "she is restless because she is in a status of meeting a new doctor."

4) Respondent uses an unclear description for T.T.'s thoughts, "Linear but blocked." The same phrase issued in the charts for patient R.S. on June 22 and patient A.S. on November 10, 2011.

5) Respondent uses unusual syntax, formatting and abbreviations which makes comprehension difficult. For example, "se" is short for side effect; d/c for "discussed," though later she uses it on the same page to be mean "discontinue" (as for Ambien) and "discussed" (as for Seroquel prescription). The use of terms "HPI" (history of present illness), "PMI" (past medical history), "SH" (presumably substance history), and "meds," which are all common subject headings used in psychiatry, contain information from other categories, creating confusion when reading the record.

6) Other than a perfunctory "patient is oriented to time, place, person, and situations[;] she is alert and responsive...," there is no clear evaluation of cognition or possible level of inebriation. A patient may be alert and oriented but have significant cognitive deficits. Similarly, intoxication is a diagnosis to be considered or rule out for this patient.

C. Much of Respondent's records are copied and pasted from other records and therefore not unique to this patient. For example:

1) At the beginning of the mental status of examination of February 10, 2012, Respondent observes, "The patient is inappropriately groomed and dressed, wearing a white T-shirt and Jeans." This same phrase is used in the mental status examination for patient R.S. on June 22, 2012. It is also used in the intake of patient A.S., on November 10, 2011.

2) Respondent describes T.T's ability to do analogies In February: " When asked to tell me the difference of shoes and socks the patient answers both are located at bottom." She used the same phrase for R.S. on June 22, 2012, and A.S, on November 10, 2010.

D. Respondent's records are inadequate and contradictory as follows:

1) While the first sentence of the history of present illness describes "she has noticed persistent hyperactive with pressured speech disorganized thoughts and behaviors...,"

this is in conflict with the Mental Status Examination (MSE): "mood is sad and depressed."

2) The copy and paste technique resulted also in contradictory information: In the intake note of T.T., in February, Respondent includes medications under "past psychiatric history" but omits Neurontin. Four pages later under "meds" T.T is taking Neurontin. In the history of present illness and past psychiatric history she describes in three different paragraphs a significant history of chaotic substance abuse and alcohol abuse but then under substance history "patient denies recent tobacco use or recreational drug use. Occasional alcohol consumption."

E. For the second visit, June 29, 2012, Respondent has not written a mental status examination.

16. The standard of care in medicine and in the treatment of psychiatric patients requires documentation of the patient's visit. This must include but is not limited to a detailed description of the presenting problem; psychiatric history, recent and past, including prior treating therapists, hospitalizations, medications and interventions; a listing of past suicidal or violent acts; a history of substance abuse; a recording of medical treatments including past illnesses, hospitalizations, current conditions, medications and treatment; social history including family history, and history of trauma; education, military service, employment, economic status and spiritual involvement; legal history; marriage, relationships, siblings and offspring. Special attention should be made to the interaction of recent changes in this catalogue of factors and the clinical presentation of the patient.

17. The standard of care requires a medical record that clearly documents events in the office. This document should be easily readable in English so that future physicians, outside agencies and even the patient can understand the history of treatment. The written story of the meeting between the physician and the patient should honestly, unambiguously, and reliably enable any psychiatrist to follow along from presenting problem through examination to diagnosis and treatment. The psychiatric record cannot be written in code, idiosyncratic abbreviations, disjointed formatting or esoteric jargon that no one but the author can decipher, since the goal of the record is to communicate to subsequent readers what happened in the office.

18. The standard of psychiatric care requires a mental status examination. Though Respondent did mention that "informed consent signed by patient" in both visits, there is insufficient discussion as to this patient's capacity to give informed consent given her agitated state on both occasions.

19. Much of the physical examination on both days focused on the musculoskeletal system and pain in this system. There is no examination of other organ systems. Though it is not standard of care for a psychiatrist to perform a physical exam, this kind of examination, focusing on the musculoskeletal systems indicates that she has pasted the physical evaluation, and for that matter, a great deal of the notes of a clinic colleague, who specializes in treatment of muscular-skeletal pain and acupuncture. The failure to attribute authorship to the colleague's notes leads to a hybrid record from both Respondent and the colleague. About half of the notes on these two days are in reality produced by the colleague. There is no way of knowing where the boundary is between Respondent's notes and the colleague's notes.

20. The standard of care for documentation of medical visits requires the avoidance of plagiarism, and the attribution to other authors or physicians of information obtained from them.

21. Both records are a mix of copy and pastes, plagiarism and omissions that are neither coherent nor historically accurate. These records do not document that an appropriate prior examination was performed. Though there is a note that labs will be done, lab results are not referenced in the intake or return visit.

22. The standard of care for documentation of medical visits and for prescription of medication requires an appropriate prior examination of the patient with delineation of pertinent positives and negatives and faithful documentation of the history, symptoms, physical exam and mental status examination.

23. The Practice Guideline for the Treatment of patients with Bipolar Disorder (Revision) supplement to the American Journal of Psychiatry, (Vol. 159 #4 April 2002) states at page 5:

"Initial treatment of bipolar disorder requires a thorough assessment of the patient, with particular attention to the safety of the patient, and those around him or her as well as

attention to possible comorbid psychiatric or medical illnesses. In addition to the current mood state, the clinician needs to consider the longitudinal history of the patient's illness."

24. Respondent did not obtain a physical evaluation including physical examination and laboratory tests: TSH, CBC, RPR, Creatinine, ALT, B12, folate and others. THS measures thyroid function. In order to prescribe thyroid hormone (levothroid), a physician must know the level of thyroid function, usually by obtaining a TSH. There was no accurate listing of current medications prescribed by others or obtained over-the-counter. There was no catalogue of when the patient last drank alcohol or used drugs. There was no clear questioning concerning head trauma, surgery, or medical diagnosis. Cognitive testing was superficial if it occurred at all. Cognitive testing of the patient's abilities could have been accomplished with the Folstein Minimental Status Exam, MOCA, the clock test or detailed questioning.

25. The standard of care requires a physical assessment of populations where physical illness may be comorbid. This includes vital signs in special situations requiring awareness of this data, such as patients presenting with acute physical symptoms (fainting, chest pain, and diaphoresis). If not obtained in the psychiatrist's office, this examination can be performed by a nurse or generalist with the results recorded in the psychiatric notes. Patients with possible metabolic syndrome, anorexia, and weight gain or loss due to psychiatric conditions should have their weight obtained in the office or by another clinician. Patients who are stable need not have vital signs taken on every visit but should be referred to a generalist to screen for medical disorders.

26. The standard of care for psychiatrists requires recognition of concurrent or comorbid medical or physical conditions and medications. Not only must a medical history and review of systems be obtained, but a listing of all medications taken, including those prescribed by non-psychiatrists elsewhere, over-the-counter medications, dosages and durations. Usually this entails obtaining and recording common screening laboratory tests including but not limited to CBC, TSH, ALT, creatinine, FBS. Some patient populations also require awareness of pregnancy testing as well as such lab tests as Folate, B-12 levels, lipid panel, serum electrolytes, lithium, valproate, carbamazepine levels, ESR and RPR.

27. Respondent was grossly negligent in his care and treatment of patient T.T. as follows:

A. Respondent failed to clearly document the events in her office, as described above.

B. Respondent used plagiarized portions of her colleague's records and pasted from other patient's examination records, as described above.

C. Respondent failed to perform an appropriate examination prior to prescribing medications, as described above.

D. Respondent failed to consider comorbid medical conditions in her treatment of T.T., as described above.

Patient R.S.

28. On or about August 9, 2012, J.S., the husband of patient R.S., filed a complaint with the Board stating:

"[Respondent] has made 5 phone calls (one hour call) and text. Asking my wife to testify [that Respondent's colleague] touched her inappropriately. My wife said it is not true, she was treated appropriately and getting better, and I with my wife whole time. But she won't give up, keep calling and texting ask my wife to testify against [the clinic colleague] with details she instructed how my wife was touched inappropriately. She also tell my wife she can take care of her/my wife for the rest of her life with all medication she needs. My wife has already had anxiety problems, with [Respondent's] constant nagging and 'coaching' I felt [Respondent] is try to 'brain wash' my wife, it is really distress and upset my wife and she was becoming very sick and could not sleep. Her family and I are very irritated and shocked by [Respondent's] behavior. Please protect us from harassing and brain washing from this doctor"

29. R.S. saw Respondent once, on June 22, 2012, for panic, anxiety and worry dating back to sexual abuse from a babysitter. Respondent took a history. R.S. had never seen a psychiatrist but got Zoloft from her primary care doctor, which caused a rash. Respondent noted that the patient was appropriately groomed and dressed, "wearing a white T-shirt and jeans." When asked "tell me the difference of shoes and socks," the patient answered, "both are located at bottom."

She diagnosed Axis I generalized anxiety disorder and post-traumatic stress disorder. Respondent prescribed Benadryl 50 mg three times daily, Cymbalta 20 mg once daily, and Xanax 2 mg twice a day.

30. The American Psychiatric Association's "The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry," (2009 Edition Revised,) states:

"Section 1. A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights. A psychiatrist shall not gratify his or her own needs by exploiting the patient. The psychiatrist shall be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor–patient relationship, and thus upon the well-being of the patient. These requirements become particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.

"Section 2. A physician shall uphold the standards of professionalism, be honest in all professional interactions and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.

"1. The requirement that the physician conduct himself/herself with propriety in his or her profession and in all the actions of his or her life is especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her psychiatrist by identification.

"Section 3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements, which are contrary to the best interests of the patient.

"1. It would seem self-evident that a psychiatrist who is a law-breaker might be ethically unsuited to practice his or her profession. When such illegal activities bear directly upon his or her practice, this would obviously be the case.

["...."]

"Section 8. A physician shall, while caring for a patient, regard responsibility to the patient as paramount."

31. Though Respondent denied any such exploitive phone calls to R.S. during her

interview at the Medical Board, one phone call was recorded on July 30, 2012. During the call, Respondent made requests to serve Respondent's purpose of harming her clinic colleague. Not only does this exploit patient R.S. who is perhaps vulnerable due to her history, but represents an attempt to seduce her into committing perjury. During the visit on June 22, 2012, Respondent prescribed Xanax 2 mg which is an aggressive, potentially addictive dose to R.S. The mixing of Respondent's own personal problems with the treatment and problems of R.S. is commonly labeled a "boundary violation." Respondent did not place her responsibility to the patient paramount, was dishonest and set a bad example to this patient by trying to conspire with the patient to commit a crime.

32. Respondent was grossly negligent in her care and treatment of patient R.S. as follows: Respondent made repetitive phone calls to her patient R.S. attempting to bribe her with medication to perjure herself by accusing Respondent's clinic colleague of sexual improprieties.

33. Respondent was grossly negligent in her care and treatment of patient R.S. by failing to keep accurate records; by using copy and paste plagiarism; and by failing to perform an appropriate prior examination.

Patient A.S.

34. Respondent treated A.S., a 54-year-old man at the Garden Oasis Clinic from May 10, 2011, through June 8, 2012. He was given a diagnosis of "schizophreniform disorder chronic state" and "anxiety disorder in conditions classified elsewhere." He was at first treated with Trileptal and risperidone but this was later switched to Trileptal 1200 mg divided daily and Latuda 80 mg daily and risperidone was stopped. The last documented prescription of this was on June 8, 2012. Respondent was locked out of her office July 3, 2012. The prescriptions on the Truxton pad was written 10 days after Respondent lost access to her office.

35. The standard of care is set forth in The American Psychiatric Association's "The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry," (2009 Edition Revised) Section 3, which states:

"A physician shall respect the law and also recognize a responsibility to seek changes in those requirements, which are contrary to the best interests of the patient. 1. It would seem

self-evident that a psychiatrist who is a law-breaker might be ethically unsuited to practice his or her profession. When such illegal activities bear directly upon his or her practice, this would obviously be the case."

36. Many of the same record deficiencies discussed concerning patient T.T. are evident also in the record of A.S.. This includes plagiarism of her clinic colleague's notes, repetition of trite phrases that could signify positive, important symptoms but appear word for word in the charts of T.T., R.S., and D.J. Examples are the phrase concerning the "white T shirt and jeans;" the phrase about "socks and shoes" being "at the bottom;" and the phrase "thought process is linear but blocked" which appeared in the charts of T.T., R.S., A.S. and D.J. The vital signs of blood pressure 127/82 and pulse 87 appear month to month in Respondent's charting of A.S. Despite documentation of receiving lisinopril and metformin there are no standard laboratory tests and no discussion of medical conditions.

37. Respondent was grossly negligent in her care and treatment of patient A.S, by failing to keep accurate records; by using of copy and paste plagiarism; and by the failing to perform an appropriate examination prior to treating and prescribing.

Patient D.J.

38. On or about October 2, 2012, patient D.J. filed a complained against Respondent stating that:

"On November 11, 2011 [Respondent] used Topamax [to] help me lose weight. I start to lose memorial not lose weight, and I keep teller her, but she ignore and keep increasing it till I can't play piano and cannot function. I have to stop take it by myself. I was doing good on my bipolar meds, but she told me my psych meds are poison needs to change, so she change it, then I went into a spending madness loss all my money." (sic)

39. D.J. was a 62-year-old woman seen by Respondent at the Garden Oasis Medical Group from October 7, 2011, through June 22, 2012. Her presenting complaint was being "extremely happy" and having "too many ideas in her head." She used to be an addict but was now sober for 25 years. She had prior thoughts of wanting to kill her husband. Respondent diagnosed her with "drug dependence excluding opioid type drug" and "bipolar I disorder most

recent episode manic." Respondent's initial plan was to continue Seroquel 800 mg daily, Abilify 2 mg daily, temazepam 30 mg "with tapering down" and to add cyproheptadine 4 mg at sleep time.

40. On the next visit on or about October 24, 2011, Abilify was increased to a higher dose, 10 mg at bedtime, temazepam decreased to 15 mg and cyproheptadine increased to 8 mg at night. There were many frequent office visits from the autumn through winter to spring. In the November 7, 2011, visit there was no order for Topamax, but on December 16, 2011, Respondent continued to prescribe cyproheptadine 8 mg, temazepam 15 mg, Abilify 15 mg at night and Seroquel perhaps 600 mg daily. (The Seroquel situation is confusing since there were two prescriptions noted). On December 30, 2011, there is an order for Topamax 450 mg daily. By the end of December, D.J. was taking Topamax 450 mg daily. There was an ambiguous doctors note on the medical record, dated December 30, 2011, stating that the patient was confused, necessitating decreasing the dose of Topamax from 300 to 200 mg daily. The doctors notes are ambiguous. Thyroid medication was now added at 50 mcg daily.

41. On January 6, 13, 16 and 27, 2012, February 17, 24, March 23, and April 13, 2012, D.J. continued to receive 650 mg Topamax a day. On May 18, 2012, this was reduced to 500 mg daily and was reduced further on June 22, 2012. The standard of care is reflected in "The Prescriber's Guide" by Stephen Stahl (2011) which states at page 591, regarding Topamax: "Not clear that it has mood-stabilizing properties but some bipolar patients may respond and if so, it may take several weeks to months to optimize an effect on mood stabilization." At page 592 a dose of 50-300 mg is recommended as "adjunctive treatment" for bipolar disorder. In addition, it is noted that "many bipolar patients do not tolerate more than 200 mg/day. Weight loss is dose – related but most patients treated for weight gain receive doses at the lower end of the dosing range." On page 591, it states that "notable side effects are sedation, asthenia, dizziness, ataxia, parasthesia, nervousness, nystagmus [and] tremor." There is a recommendation on page 593, that "dosage should be reduced by half for renal insufficiency and elderly patient may be more susceptible to adverse effects."

42. The chaotic charting of Respondent's records leaves some ambiguity as to when

medications and doses were altered. The use of Topamax in the treatment of mania is not recommended according to Steven's Stahl "The Prescriber's Guide." In addition the dose she received, for some weeks 650 mg, is over twice the recommended maximum dose for bipolar disorder. The Practice Guidelines for treatment of patients with bipolar disorder of the APA warn of the risk of side effects with polypharmacy. D.J. received, along with very high dose of Topamax, Seroquel of about 500 mg daily, cyproheptadine 4-8 mg, Abilify 15-25 mg and temazepam. Cyproheptadine and Benadryl, both antihistamines, are sedating. High doses of Topamax can be sedating. Despite Respondent making a minor alteration in dosing, she continued to prescribe doses far above recommended doses along with high dose Seroquel and a sleeping pill and antihistamines. Topamax is not effective for bipolar disorder, so the risks far outweigh the benefits. Though Respondent recognized sedation was resulting from the polypharmacy, there was only a minor alteration of dosage. She failed to respond to D.J.'s difficulties with the medication by correcting her prescribing errors, researching the dosage and using alternative approaches.

43. Respondent was grossly negligent in her care and treatment of patient D.J. for using high dose polypharmacy and doses of Topamax more than twice the recommended dosage.

44. The standard of care in medicine and in the treatment of psychiatric patients requires documentation of the patient's visit. This must include but is not limited to a detailed description of the presenting problem; a psychiatric history, recent and past, including prior treating therapists, hospitalizations, medications and interventions; a listing of past suicidal or violent acts; a history of substance abuse; a recording of medical treatments including past illnesses, hospitalizations, current conditions, medications and treatment; a social history including family history, history of trauma, education, military service, employment, economic status and spiritual involvement; a legal history; and a history of marriage, relationships, siblings and offspring. Special attention should be paid to the interaction of recent changes in this catalogue of factors and the clinical presentation of the patient.

45. The standard of care requires a medical record that clearly documents events in the office. This document should be easily readable in English so that future physicians, outside

agencies and even the patient can understand the history of treatment. The written picture of the meeting between physician and patient should honestly, unambiguously, and reliably enable any psychiatrist to follow along from presenting problem through examination to diagnosis and treatment. The psychiatric record cannot be written in code, idiosyncratic abbreviations, disjointed formatting or esoteric jargon that no one but the author can decipher since the goal of the record is to communicate to others what happened in the office. The standard of psychiatric care requires a mental status examination.

46. Respondent was grossly negligent in her care and treatment of patient D.J. in her documentation of the patient visits.

47. The standard of care for documentation of medical visits is the absence of plagiarism, and instead the attribution to other authors or physicians information obtained from them. A large portion of the record produced by Respondent under her name during the treatment of D.J. is actually taken from the notes of her clinic colleague. Respondent produced a false record for which she billed Medicare, Medi-Cal, and/or insurance providers.

48. Respondent was grossly negligent in her care and treatment of patient D.J. by dishonestly using plagiarism and copy/paste to write D.J.'s psychiatric record.

49. The standard of care for documentation of medical visits and for prescription of medication requires an "appropriate prior examination" of the patient with delineation of pertinent positives and negatives. The confusing structure of the chart with repeating information and irrelevant, borrowed, pasted entries makes following events very difficult. Furthermore, since most of the record of D.J.'s treatment is a copy of the pre-existing record, that clinical status of the patient, and what happened in the office is unclear.

50. Respondent was grossly negligent in her care and treatment of patient D.J. by failing to keep a reliable record of D.J.'s treatment.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

51. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that she was repeatedly negligent in the care and treatment of Patients T.T., A.S., C.S. and D.J.

The facts and circumstances alleged in the First Cause For Discipline are incorporated here as if fully set forth.

Garden Oasis Medical Group

52. On or about October 20, 2011, Respondent, a psychiatrist, started a private practice, as a private contractor hired by the physician owner of the Garden Oasis Medical Clinic in Bakersfield, California. He referred to Respondent his chronic pain patients whom she treated for their psychiatric problems utilizing the physician owner's office space, electronic medical record and computer for which she paid a percentage of her revenue. On July 3, 2012, based on multiple complaints from patients and other psychiatrist, the physician owner terminated the relationship with Respondent, and locked her out of his business.

53. On July 7, 2012, the physician owner received a call from the Bakersfield Police that Respondent was attempting to break into his office. Respondent was apprehended but not arrested. The physician owner pursued a restraining order in court in which he says Respondent was harassing him when she tried to break into his office through a window, damaging his garden and the interior of his building. Respondent stated in an interview that she was trying to retrieve a computer which she claimed belonged to her.

54. The American Psychiatric Association's "The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry," (2009 Edition Revised) states at Section 2:

"A physician shall uphold the standards of professionalism, be honest in all professional interactions and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.

"1. The requirement that the physician conduct himself/herself with propriety in his or her profession and in all the actions of his or her life is especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her psychiatrist by identification.

"Section 3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements, which are contrary to the best interests of the patient. It would seem self-evident that a psychiatrist who is a law-breaker might be ethically unsuited

to practice his or her profession. When such illegal activities bear directly upon his or her practice, this would obviously be the case. "

55. Respondent did not seek to obtain this computer or its patient files by legal recourse through the courts; instead she attempted to break into the Garden Oasis Clinic on a Saturday evening. Respondent violated the American Psychiatric Association Principles of Medical Ethics. Respondents acts, were not "professional" or "honest." This represents a departure from the standard of care.

Truxton Psychiatric Medical Group (Truxton) and record keeping for patients T.T., R.S., A.S., and D.J.

56. On or about August 21, 2012, M.F. who represents Truxton, reported that Respondent was writing prescriptions on the Truxton prescription pads though she was no longer working there.

57. On or about June 18, 2010, Respondent was terminated from the Truxton. Thereafter, she wrote prescriptions on Truxton prescription pads from this group for patient A.S. on July 13, 2012. Patient A.S. has never been patients of Truxton.

58. The association of Truxton with Respondent was terminated on June 18, 2010. Respondent's use thereafter of the Truxton script represents a "boundary issue." The use of the Truxton pharmacy pad by Respondent can give the appearance that the patients who received prescriptions from Respondent are treated by Truxton. This casts a liability risk onto Truxton. Furthermore, the reputation of Truxton is then tied to Respondent. This represents a departure from the standard of care.

Patient T.T.

59. Respondent was negligent in his care and treatment of patient T.T.. as follows:

A. Respondent failed to clearly document the events in her office, as described above.

B. Respondent used plagiarized portions of her clinical colleague's records and pasted from other patient's examination records, as described above.

C. Respondent failed to perform an appropriate examination prior to prescribing

medications, as described above.

D. Respondent failed to consider comorbid medical conditions in her treatment of T.T., as described above.

E. Respondent failed to include elements in the records that are found in most psychiatric records, as described above.

Patient R.S.

60. Respondent was negligent in her care and treatment of patient R.S. when she made repetitive phone calls to her patient R.S. attempting to bribe her with medication to perjure herself by accusing Respondent's clinical colleague of sexual improprieties.

Truxton Psychiatric Medical Group (Truxton) and record keeping for patients T.T., R.S., A.S., and D.J.

61. Respondent was negligent in her practice of medicine as follows:

A. In her care and treatment of patients T.T., R.S., A.S, and D.J. by failing to keep accurate records; by using of copy and paste plagiarism; and by failing to perform appropriate prior examinations.

B. In her care and treatment of patient A.S. by failing to perform an appropriate examination prior to treating and prescribing.

C. By unilaterally using the prescription pad of Truxton, to write prescriptions to A.S. after she no longer worked there.

Patient D.J.

62. Respondent was negligent in her care and treatment of patient D.J. as follows:

A. For using high dose polypharmacy and doses of Topamax more than twice the recommended dosage.

B. In her documentation of the visits.

C. In her care and treatment of patient D.J. by dishonestly using plagiarism and copy/paste to write D.J.'s psychiatric record.

D. By failing to keep a reliable record of D.J.'s treatment. Most of the record was copied and pasted from the earlier records.

63. Respondent was negligent in her practice of medicine by seeking possession of a computer by extra-legal means.

THIRD CAUSE FOR DISCIPLINE

(Dishonest Acts)

64. Respondent is subject to disciplinary action under Code section 2234, subdivision (e), in that she was dishonest in the course of providing medical services. The fact and circumstances alleged above in the First and Second Causes for Discipline are incorporated here as if fully set forth.

65. More specifically, Respondent was dishonest as follows:

A. When she made repetitive phone calls to her patient R.S. attempting to bribe her with medication to perjure herself by accusing the physician owner of the Garden Oasis Clinic of sexual improprieties.

B. When she used plagiarism and copy/paste to write D.J.'s psychiatric record.

C. When she called 911 many times with false accusations that the physician owner of the Garden Oasis clinic had sexually assaulted patients.

D. When she continued to use the prescription pads of Truxton, after she was no longer employed there.

FOURTH CAUSE FOR DISCIPLINE

(Incompetence)

66. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that she was incompetent in the care and treatment of patients T.T., A.S. and D.J. The facts and circumstances alleged above in the First, Second, and Third Causes for Discipline are incorporated here as if fully set forth.

Patient T.T.

67. Respondent was incompetent in her care and treatment of patient T.T. as follows:

A. Respondent lacks knowledge concerning the use of medication in manic patients.

B. Respondent lacks knowledge concerning the basic elements of a psychiatric evaluation, and appropriate differential diagnosis, in particular relating to bipolar patients, omitting concerns of physical diagnosis, substance use, safety, self-care and compliance.

Patients A.S. and T.T.

68. The Practice Guideline for the Treatment of Patients with Bipolar Disorder (Revision) supplement to the American Journal of Psychiatry, vol. 159 #4 April 2002, on Page 5 states:

"Initial treatment of bipolar disorder requires a thorough assessment of the patient, with particular attention to the safety of the patient, and those around him or her as well as attention to possible comorbid psychiatric or medial illnesses. In addition to the current mood state, the clinician needs to consider the longitudinal history of the patient's illness."

69. The "Practice Guideline for the Treatment of Patients with Bipolar Disorder" (Revision) supplement to the American Journal of Psychiatry, (vol. 159 #4 April 2002) states on page 6:

"[The] patient with bipolar disorder often requires such combinations in order to achieve adequate symptom control and prophylaxis against future episodes. However, each additional medication generally increases the side effect burden and the likeliness of drug-drug interactions or other toxicity and therefore must be assessed in terms of the risk-benefit ratio in the individual patient."

"Lack of insight or minimization is often a prominent part of bipolar disorder and may at times interfere with the patient's ability to make reasoned treatment decisions, necessitating the involvement of family members or significant others in treatment whenever possible."

70. The "Practice Guideline for the Treatment of Patients with Bipolar Disorder" (Revision) supplement to the American Journal of Psychiatry, (vol. 159 #4 April 2002) state on page 9:

"For patients who despite receiving the aforementioned medications, experience a 'manic or breakthrough episode' the first line of intervention would be to optimize the medication dose. Optimization of dosage entails ensuring that the blood level is in the therapeutic

range and in some cases achieving a higher serum level although one still within the therapeutic range).

The Guidelines further state at page 23:

"[C]bc's, platelet measurements and liver function tests should be performed every 2 weeks during the first 2 months of carbamazepine treatment. Thereafter, if results of laboratory tests remain normal and no symptoms of bone marrow suppression or hepatitis appear blood counts and liver function tests should be performed at least every 3 months."

71. The standard of care for psychiatrists requires recognition of concurrent or comorbid medical or physical conditions and medications. Not only must a medical history and review of systems be obtained, but a listing of all medications taken, including those prescribed by non-psychiatrists elsewhere, over-the-counter medications, dosages and durations. Usually this entails obtaining and recording common screening laboratory tests including but not limited to CBC, TSH, ALT, creatinine, and FBS. Some patient populations also require awareness of pregnancy testing. Folate B-12 levels, lipid panel, serum electrolytes, lithium, valproate, carbamazepine levels, ESR and RPR may be required. Concerning physical examination including vital signs, special conditions may require awareness of this data, for example new patients and patients presenting with acute physical symptoms (fainting, chest pain, diaphoresis). If not obtained in the psychiatrist's office, this examination can be performed by a nurse or generalist with the results recorded in the psychiatric notes. Patients with possible metabolic syndrome, anorexia, and weight gain or loss due to psychiatric conditions should have their weight obtained in the office or by another clinician. Patients who are stable need not have vital signs taken on every visit but should be referred to a generalist to screen for medical disorders.

72. Respondent was incompetent in her treatment of A.S. and T.T. when she showed a lack of knowledge by her failure to pursue possible comorbid medical conditions, her failure to perform and document standards laboratory tests for physical conditions; her failure to involve consultants; and her failure to understand the connections between presenting illness, examination, diagnosis and treatment.

Patient D.J.

73. The standard of care for the elderly and those who abuse substances requires awareness of possible impairment of cognition. This usually requires screening using either a common in-office paper and pencil exam (clock test, MMSE, MOCA) or exploration of memory judgment and concentration by some reliable means.

74. Respondent was incompetent in the treatment of bipolar patient D.J. as follows:

A. D.J. was prescribed Levothroid without a TSH.

B. There are no screening labs to rule out common illnesses in the middle age.

C. There is no recorded communication with a primary care physician.

D. Pertinent for Topamax prescribing, there are neither screening for renal functions nor electrolytes, nor CBC, TSH, ALT, FBS, HG, A1c, or Lipid Panel tests.

E. There is no urine toxicology test.

F. Respondent failed to consider physical conditions, pursue and document medical issues, and to screen and follow metabolic, endocrinologic and other conditions with appropriate laboratory tests.

G. Respondent failed to screen patient D.J. for possible impairment of cognition.

FIFTH CAUSE FOR DISCIPLINE

(Prescribing without an Appropriate Prior Examination)

75. Respondent is subject to disciplinary action under Code section 2242, subdivision (a), in that she prescribed medications to patients T.T. and A.S. without an appropriate prior examination. The fact and circumstances alleged above in the First, Second, Third, and Fourth Causes for Discipline, are incorporated here as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

76. Respondent is subject to disciplinary action under Code section 2266, in that she failed to maintain adequate and accurate records relating to the provision of medical services to patients T.T, A.S., R.S, and D.J. The fact and circumstances alleged above in the First, Second, Third, and Fourth Causes for Discipline, are incorporated here as if fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

77. Respondent is subject to disciplinary action under Code section 2234 in that she engaged in unprofessional conduct in care and treatment of patients. The facts and circumstances alleged above in paragraphs 12 through 76 are incorporated here as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 102651, issued to Shiquan Xiong, M.D.;

3. Revoking, suspending or denying approval of Shiquan Xiong, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

4. Ordering Shiquan Xiong, M.D. to pay the Medical Board of California, if placed on probation, the costs of probation monitoring; and

5. Taking such other and further action as deemed necessary and proper.

DATED: May 15, 2014

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA201361301