

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

In the Matter of the Accusation )  
Against: )  
)  
)  
**JOHN W. ALLEN, M.D.** )  
)  
Physician's and Surgeon's )  
Certificate No. C 37706 )  
)  
Respondent )  
\_\_\_\_\_ )

File No. 10-2005-165675

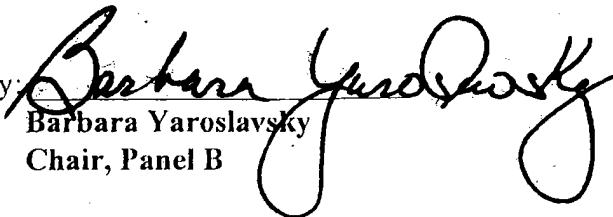
DECISION

The attached Proposed Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on **October 16, 2008.**

IT IS SO ORDERED **September 16, 2008.**

MEDICAL BOARD OF CALIFORNIA

By:   
Barbara Yaroslavsky  
Chair, Panel B

1 EDMUND G. BROWN JR., Attorney General  
of the State of California  
2 THOMAS S. LAZAR  
Supervising Deputy Attorney General  
3 SAMUEL K. HAMMOND, State Bar No. 141135  
Deputy Attorney General  
4 California Department of Justice  
110 West "A" Street, Suite 1100  
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6 P.O. Box 85266  
San Diego, CA 92186-5266  
7 Telephone: (619) 645-2083  
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8

9 Attorneys for Complainant

10  
11 **BEFORE THE**  
**THE MEDICAL BOARD OF CALIFORNIA**  
**DEPARTMENT OF CONSUMER AFFAIRS**  
12 **STATE OF CALIFORNIA**

13 In the Matter of the Accusation Against:  
14 **JOHN W. ALLEN, M.D.**  
11238 Quail Canyon Road  
15 El Cajon, CA 92021  
16 Physician's and Surgeon's Certificate  
No. C 37706  
17  
18 Respondent.

Case No. 10-2005-165675  
OAH No. L-2007120678  
**STIPULATED SETTLEMENT AND  
DISCIPLINARY ORDER**

19  
20 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the  
21 above-entitled proceedings that the following matters are true:

22 PARTIES

23 1. Barbara Johnston (Complainant) is the Executive Director of the Medical  
24 Board of California and is represented in this matter by Edmund G. Brown Jr., Attorney General  
25 of the State of California, by Samuel K. Hammond, Deputy Attorney General.

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1 CULPABILITY

2 8. Respondent does not contest that at an administrative hearing, complainant  
3 could establish a *prima facie* case with respect to the charges and allegations contained in  
4 Accusation No. 10-2005-16565, and that he has thereby subjected his Physician's and Surgeon's  
5 Certificate No. C 37706 to disciplinary action. Respondent agrees to be bound by the Board's  
6 imposition of discipline as set forth in the Disciplinary Order below.

7 CONTINGENCY

8 9. The parties agree that this Stipulated Settlement and Disciplinary Order  
9 shall be submitted to the Board for its consideration in the above-entitled matter and, further, that  
10 the Board shall have a reasonable period of time in which to consider and act on this Stipulated  
11 Settlement and Disciplinary Order after receiving it.

12 10. The parties agree that this Stipulated Settlement and Disciplinary Order  
13 shall be null and void and not binding upon the parties unless approved and adopted by the  
14 Board, except for this paragraph, which shall remain in full force and effect. Respondent fully  
15 understands and agrees that in deciding whether or not to approve and adopt this Stipulated  
16 Settlement and Disciplinary Order, the Board may receive oral and written communications from  
17 its staff and/or the Attorney General's office. Communications pursuant to this paragraph shall  
18 not disqualify the Board, any member thereof, and/or any other person from future participation  
19 in this or any other matter affecting or involving respondent. In the event that the Board, in its  
20 discretion, does not approve and adopt this Stipulated Settlement and Disciplinary Order, with  
21 the exception of this paragraph, it shall not become effective, shall be of no evidentiary value  
22 whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party  
23 hereto. Respondent further agrees that should the Board reject this Stipulated Settlement and  
24 Disciplinary Order for any reason, respondent will assert no claim that the Board, or any member  
25 thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated  
26 Settlement and Disciplinary Order or of any matter or matters related hereto.

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1 ADDITIONAL PROVISIONS

2 11. This Stipulated Settlement and Disciplinary Order is intended by the  
3 parties herein to be an integrated writing representing the complete, final and exclusive  
4 embodiment of the agreements of the parties in the above-entitled matter.

5 12. The parties agree that facsimile copies of this Stipulated Settlement and  
6 Disciplinary Order, including facsimile signatures of the parties, may be used in lieu of original  
7 documents and signatures and, further, that facsimile copies shall have the same force and effect  
8 as originals.

9 13. In consideration of the foregoing admissions and stipulations, the parties  
10 agree the Board may, without further notice to or opportunity to be heard by respondent, issue  
11 and enter the following Decision and Disciplinary Order:

12 DISCIPLINARY ORDER

13 A. PUBLIC REPRIMAND

14 IT IS HEREBY ORDERED that respondent John W. Allen, M.D., Physician's and  
15 Surgeon's Certificate No. C 37706, shall be Publicly Reprimanded pursuant to California  
16 Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand shall be  
17 issued in connection with respondent's care and treatment of patient C.H. as set forth in  
18 Accusation No. 10-2005-165675, as follows:

19 Between about December 19, 2004 and February 22, 2005, you provided  
20 psychiatric care to patient C.H. at the Alvarado Parkway Institute (API). Patient C.H. had been  
21 transported to API by the police who found him naked on the public street. Patient C.H. had a  
22 medical history that included treatment-resistant paranoid schizophrenia and poly-substance  
23 abuse, and he had suffered numerous prior admissions to API with poor response to antipsychotic  
24 treatments. In about May 2002, patient C.H. was prescribed Clozapine which caused a drop in  
25 his white blood cells (WBC). Because of this adverse reaction to Clozapine, patient C.H. was  
26 placed on the manufacturer's registry's "Do Not Re-Challenge" list. On January 31, 2005, you  
27 initiated treatment with Clozaril (Clozapine) 25 mg. per day because patient C.H.'s auditory  
28 hallucinations, delusional thoughts and threatening behavior did not improve despite treatment

1 with several other anti-psychotic drugs. You increased the Clozaril dosage daily until  
2 February 13, 2005, when patient C.H. was administered a maximum daily dosage of 300 mg. per  
3 day. The Clozaril medication caused a life-threatening drop of patient C.H.'s WBC requiring  
4 admission to the ICU.

5           You initiated treatment with Clorazil without reviewing patient C.H.'s medical  
6 records at API to determine if he had ever been prescribed ClozariI. Also, you failed to  
7 adequately supervise and monitor patient C.H.'s WBC between February 11, 2005 and February  
8 22, 2005, and you failed to adequately supervise staff to ensure the "weekly WBC checks"  
9 required for patients on Clozaril. Said conduct constitutes unprofessional conduct in violation of  
10 Code section 2234, subdivision (c).

11           **B.     PRESCRIBING PRACTICES COURSE** Within 60 calendar days of  
12 the effective date of this decision, respondent shall enroll in a course in prescribing practices, at  
13 respondent's expense, approved in advance by the Board or its designee. Failure to successfully  
14 complete the course during the first 6 months of probation is a violation of probation and grounds  
15 for further disciplinary action.

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

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

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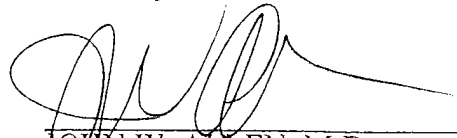
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1 ACCEPTANCE

2 I have carefully read the above Stipulated Settlement and Disciplinary Order and  
3 have fully discussed it with my attorney, Robert W. Frank, Esq. I fully understand the stipulation  
4 and the effect it will have on my Physician's and Surgeon's Certificate No. C 37706. With the  
5 benefit of counsel, I enter into this Stipulated Settlement and Disciplinary Order voluntarily,  
6 knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board.

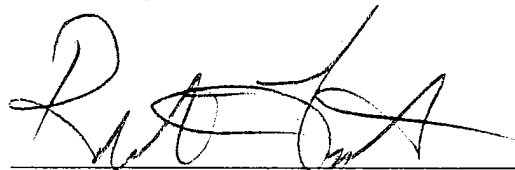
7 DATED: 7-3-08



8 \_\_\_\_\_  
9 JOHN W. ALLEN, M.D.  
Respondent

10 I have read and fully discussed with respondent John W. Allen, M.D., the terms  
11 and conditions and other matters contained in the above Stipulated Settlement and Disciplinary  
12 Order. I approve its form and content.

13 DATED: 7-3-08



14 \_\_\_\_\_  
15 ROBERT W. FRANK, ESQ.  
Attorney for Respondent

16 ENDORSEMENT

17 The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully  
18 submitted for consideration by the Board.

19 DATED: 7/3/08

20 EDMUND G. BROWN JR, Attorney General  
21 of the State of California

22 THOMAS S. LAZAR  
23 Supervising Deputy Attorney General



24 \_\_\_\_\_  
25 SAMUEL K. HAMMOND  
Deputy Attorney General

26 Attorneys for Complainant

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28 ///

**EXHIBIT A**

**ACCUSATION NO. 10-2005-165675**



1 EDMUND G. BROWN JR., Attorney General  
of the State of California  
2 THOMAS S. LAZAR  
Supervising Deputy Attorney General  
3 SAMUEL K. HAMMOND, State Bar No. 141135  
Deputy Attorney General  
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7 Telephone: (619) 645-2083  
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8 Attorneys for Complainant  
9

FILED  
STATE OF CALIFORNIA  
MEDICAL BOARD OF CALIFORNIA  
SACRAMENTO October 10, 20 07  
BY 10 [Signature] MO ANALYST

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

14 In the Matter of the Accusation Against:  
15 JOHN W. ALLEN, M.D.  
11238 Quail Canyon Road  
16 El Cajon, CA 92021  
17 Physician's and Surgeon's Certificate  
No. C 37706  
18 Respondent.  
19

Case No. 10-2005-165675

OAH No.

**ACCUSATION**

20  
21 Complainant alleges:

22 PARTIES

- 23 1. Barbara Johnston (Complainant) brings this Accusation solely in her  
24 official capacity as the Executive Director of the Medical Board of California.  
25 2. On or about October 11, 1977, the Medical Board of California issued  
26 Physician's and Surgeon's Certificate No. C 37706 to John W. Allen, M.D. (Respondent). The  
27 Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the  
28 charges brought herein and will expire on April 30, 2009, unless renewed.

JURISDICTION

1  
2           3.       This Accusation is brought before the Division of Medical Quality,  
3 Medical Board of California, Department of Consumer Affairs (Division) under the authority of  
4 the following laws. All section references are to the Business and Professions Code unless  
5 otherwise indicated.

6           4.       Section 2220 of the Code states:

7           “Except as otherwise provided by law, the Division of Medical Quality may take  
8 action against all persons guilty of violating this chapter [Chapter 5, the Medical Practice  
9 Act]. The division shall enforce and administer this article as to physician and surgeon  
10 certificate holders, and the division shall have all the powers granted in this chapter for  
11 these purposes including, but not limited to:

12           “(a) Investigating complaints from the public, from other licensees, from health  
13 care facilities, or from a division of the board that a physician and surgeon may be guilty  
14 of unprofessional conduct. The board shall investigate the circumstances underlying any  
15 report received pursuant to Section 805 within 30 days to determine if an interim  
16 suspension order or temporary restraining order should be issued. The board shall  
17 otherwise provide timely disposition of the reports received pursuant to Section 805.

18           “(b) Investigating the circumstances of practice of any physician and surgeon  
19 where there have been any judgments, settlements, or arbitration awards requiring the  
20 physician and surgeon or his or her professional liability insurer to pay an amount in  
21 damages in excess of a cumulative total of thirty thousand dollars (\$30,000) with respect  
22 to any claim that injury or damage was proximately caused by the physician's and  
23 surgeon's error, negligence, or omission.

24           “(c) Investigating the nature and causes of injuries from cases which shall be  
25 reported of a high number of judgments, settlements, or arbitration awards against a  
26 physician and surgeon.”

27           5.       Section 2227 of the Code provides that a licensee who is found guilty  
28 under the Medical Practice Act may have his or her license revoked, suspended for a period not

1 to exceed one year, placed on probation and required to pay the costs of probation monitoring, or  
2 such other action taken in relation to discipline as the Division deems proper.

3           6.       Section 2234 of the Code states:

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

7           "(a) Violating or attempting to violate, directly or indirectly, assisting in or  
8 abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5,  
9 the Medical Practice Act].

10           "(b) Gross negligence.

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

15           "(1) An initial negligent diagnosis followed by an act or omission medically  
16 appropriate for that negligent diagnosis of the patient shall constitute a single negligent  
17 act.

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

23           "(d) Incompetence.

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

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

27           "...."

1 CAUSE FOR DISCIPLINE

2 (Repeated Negligent Acts)

3 7. Respondent, John W. Allen, M.D. has subjected his Physician's and  
4 Surgeon's Certificate No. C 37706 to disciplinary action under section Code section 2234, as  
5 defined by Code section 2234, subdivision (c) in his care, treatment and management of patient  
6 C.H. The circumstances are as follows:

7 A. On or about December 19, 2004, C.H., a 38 year-old patient, was admitted,  
8 involuntarily, to the Alvarado Parkway Institute (API), a psychiatric hospital, under  
9 respondent's care. The patient had been transported to API by the police who found him  
10 naked on the public street. The patient had a medical history that included treatment-  
11 resistant paranoid schizophrenia, poly-substance dependence and diabetes mellitus II. He  
12 had suffered numerous prior psychiatric admissions at API and elsewhere, with poor  
13 response to antipsychotic drug treatments. In about May 2002, C.H. was prescribed  
14 Clozapine which caused a drop in his white blood cells (leukopenia). Because of this  
15 adverse reaction to Clozapine, C.H. was placed on the manufacturer's registry's "Do Not  
16 Re-Challenge" list.<sup>1</sup> C.H. was under a conservatorship.

17 B. Between December 19, 2004 and January 30, 2005, the patient's agitation,  
18 paranoia, suicidal ideation, intense auditory hallucinations, delusional thoughts and  
19 threatening behavior continued despite treatment with several antipsychotic drugs  
20 including Haldol, Lithium Carbonate and Geodon<sup>2</sup>.

21 \_\_\_\_\_  
22 1. Clozaril is the brand name for Clozapine. It is described in the PDR as an "atypical"  
23 anti-psychotic drug and is indicated for treatment of the management of severely schizophrenic  
24 patients. Because of the substantial risk of agranulocytosis (defined as an absolute neutrophil  
25 count of less than 500/mm<sup>3</sup>), the manufacturer of the drug (as well as manufacturers of its  
26 generic form) are required by the FDA to maintain National Registries which contain lists of all  
27 patients on the drug or its generic forms. Patients who have suffered adverse reactions to the  
28 drug are placed on "Do Not Re-Challenge" list. The Warning Label requires physicians to  
obtain White Blood Cell (WBC) count before initiation of treatment and to obtain at least  
weekly WBC counts for the first week of treatment.

2. Haldol is a brand name for Haloperidol. It is indicated for the management of  
manifestations of psychotic disorders. Lithium Carbonate is indicated for treatment of manic

1           C.       On January 31, 2005, respondent initiated treatment of the patient with  
2       Clozaril (Clozapine) 25 mg. a day with the dosage to be increased by 25 mg. a day until a  
3       maximum dosage of 300 mg. per day. Respondent initiated treatment with Clozaril  
4       without ordering a complete blood count (CBC) to obtain "a baseline" WBC count on the  
5       patient.<sup>3</sup> Further, respondent failed to review the patient's medical records of previous  
6       admissions at API to determine if the patient ever had been prescribed Clozaril, and failed  
7       to check the national registry to determine the patient had ever been prescribed Clozaril.  
8       Respondent also failed to inform the patient's family members that he was initiating  
9       treatment of the patient with Clozaril.

10           D.       The patient's Clozaril was increased (titrated) daily until the dosage of  
11       300 mg. per day was reached on or about February 13, 2005. Respondent failed to obtain  
12       the required weekly WBC count on the patient. On or about February 19, 2005, the  
13       Clozaril dosage was decreased to 200 mg. per day. On or about February 21, 2005, the  
14       patient's temperature was noted to be 101.2. On or about February 22, 2005, the patient's  
15       WBC was obtained for the first time since February 11, 2005. The WBC was 700.  
16       Respondent discontinued the Clozaril and ordered the patient transferred to another  
17       University Community Medical Center (UCMC) for medical treatment and stabilization.  
18       At UCMC, the patient's temperature was noted to be 105 and his WBC was 500. He was  
19       diagnosed with Clozaril induced neutropenia with neutropenic sepsis along with  
20       schizoaffective disorder. After treatment, the patient was transferred to the Alvarado  
21       Medical Center where he remained in the JCU for about three weeks and was discharged  
22       on or about March 24, 2005.

23       ///

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25       \_\_\_\_\_

26       episodes in manic depressive illness. Geodon is a brand name for Ziprasidone, is indicated for  
27       the treatment of schizophrenia.

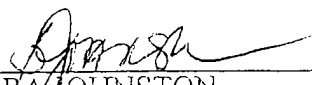
28       3. The patient's WBC count was 8,700 with 56% neutrophils on December 28, 2004; was  
      7,400 with 51% neutrophils on January 4, 2005; was 4,500 with 42.6% neutrophils on  
      February 8, 2005; and was 4,200 with 51.5% neutrophils on February 11, 2005.



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- 2. Revoking, suspending or denying approval of John W. Allen, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;
- 3. Ordering John W. Allen, M.D. to pay the Board the costs of probation monitoring if placed on probation; and
- 4. Taking such other and further action as deemed necessary and proper.

DATED: October 10, 2007

  
\_\_\_\_\_  
BARBARA JOHNSTON  
Executive Director  
Medical Board of California  
State of California  
Complainant

SD2007801510  
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