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

12 In the Matter of the Accusation Against:

Case No. 800-2021-084333

13 **PAUL RICHARD FRANCISCO, M.D.**  
14 **9 Wimbledon Circle**  
**Salinas, CA 93906**

**ACCUSATION**

15 **Physician's & Surgeon's Certificate**  
16 **No. A 82055,**

Respondent.

17  
18  
19 **PARTIES**

20 1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as  
21 the Executive Director of the Medical Board of California, Department of Consumer Affairs  
22 (Board).

23 2. On or about February 26, 2003, the Medical Board issued Physician's & Surgeon's  
24 Certificate Number A 82055 to Paul Richard Francisco, M.D. (Respondent). The Physician's &  
25 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought  
26 herein and will expire on January 31, 2027, unless renewed.

27 **JURISDICTION**

28 3. This Accusation is brought before the Board, under the authority of the following

1 laws. All section references are to the Business and Professions Code (Code) unless otherwise  
2 indicated.

3 4. Section 2004 of the Code provides that the Board shall have the responsibility for the  
4 enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

5 5. Section 2220 of the Code states:

6  
7 Except as otherwise provided by law, the Board may take action against all  
8 persons guilty of violating this chapter. The Board shall enforce and administer this  
9 article as to physician and surgeon certificate holders, including those who hold  
10 certificates that do not permit them to practice medicine, such as, but not limited to,  
11 retired, inactive, or disabled status certificate holders, and the Board shall have all the  
12 powers granted in this chapter for those purposes including, but not limited to:

13 (a) Investigating complaints from the public, from other licensees, from health  
14 care facilities, or from the board that a physician and surgeon may be guilty of  
15 unprofessional conduct. The board shall investigate the circumstances underlying a  
16 report received pursuant to Section 805 or 805.1 within 30 days to determine if an  
17 interim suspension order or temporary restraining order should be issued. The board  
18 shall otherwise provide timely disposition of the reports received pursuant to Section  
19 805 and Section 805.01.

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

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

6. Section 2227 of the Code provides that a licensee who is found guilty under the  
Medical Practice Act may have his or her license revoked, suspended for a period not to exceed  
one year, placed on probation and required to pay the costs of probation monitoring, or such other  
action taken in relation to discipline as the Board deems proper.

7. 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.

1 (b) Gross negligence.

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

6 (1) An initial negligent diagnosis followed by an act or omission medically  
7 appropriate for that negligent diagnosis of the patient shall constitute a single  
8 negligent act.

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

14 (d) Incompetence.

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

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

19 (g) The failure by a certificate holder, in the absence of good cause, to attend  
20 and participate in an interview by the board no later than 30 calendar days after being  
21 notified by the board. This subdivision shall only apply to a certificate holder who is  
22 the subject of an investigation by the board.

23 (h) Any action of the licensee, or another person acting on behalf of the  
24 licensee, intended to cause their patient or their patient's authorized representative to  
25 rescind consent to release the patient's medical records to the board or the  
26 Department of Consumer Affairs, Health Quality Investigation Unit.

27 (i) Dissuading, intimidating, or tampering with a patient, witness, or any person  
28 in an attempt to prevent them from reporting or testifying about a licensee.

#### COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

#### DEFINITIONS

9. Botox is a brand of botulinum toxin used to smooth facial wrinkles, prevent a muscle

1 from moving for a limited time, and treat neck spasms, sweating, overactive bladder, lazy eye,  
2 and other conditions.

3 10. Dermal fillers are injections used to plump up wrinkles, smooth lines, and restore  
4 volume in the face.

5 11. Juvederm is a type of dermal filler that is primarily used in the upper areas of the face  
6 to restore facial contours and improve signs of aging.

7 12. Nova Threading is a facelift procedure in which absorbable sutures are placed under  
8 the skin to tighten up the skin.

9 **FACTUAL ALLEGATIONS**

10 13. Respondent is a psychiatrist currently employed by Wellpath Care in Salinas,  
11 California. Respondent's only training was in psychiatry, and he never obtained any additional  
12 training in cosmetic procedures.

13 14. Respondent and his ex-wife, C.F., a registered nurse, jointly owned Iuvenis Clinic,  
14 Inc. (Iuvenis) in Salinas, California. Respondent was also the Chief Executive Officer at Iuvenis,  
15 but at all relevant times herein, he was employed off-site. Iuvenis was a medical practice  
16 providing medical aesthetic services, including Botox injections, dermal filler injections, laser  
17 hair removal, and Nova Threading. At Iuvenis, C.F. was the only person who provided services,  
18 including medical treatments, cosmetic filler injections, threading, and hydrofacial treatments.  
19 Respondent never saw patients, diagnosed them, or provided any medical consultations or  
20 treatments at Iuvenis, and he acknowledged that C.F. was practicing medicine unsupervised there.

21 15. In September 2019, the Board received a complaint from Patient 1,<sup>1</sup> who alleged that  
22 in November 2018, C.F. injected her and her friend with Botox, using the same needle on both  
23 individuals. Patient 1 further alleged that she saw C.F. in January 2019, when C.F. injected  
24 Botox into Patient 1's forehead. Patient 1 also alleged that in March 2019, she saw C.F. again for  
25 threading and received a face lift. Approximately one week later, Patient 1 noticed scar tissue

26 \_\_\_\_\_  
27 <sup>1</sup> Patients' actual names are not used in this Accusation to maintain patient  
28 confidentiality. Patients' identities are known to Respondent or will be disclosed to him  
upon a duly issued request for discovery and in accordance with Government Code section  
11507.6.

1 near her lips. Patient 1 additionally alleged that C.F. practiced without an active nursing license  
2 for over nine months and used products that were not what C.F. claimed to be.

3 16. During his December 12, 2023, interview with the Board, Respondent stated he  
4 “never really thought about it” and had no response when asked what a medical director’s duties  
5 were. He was also asked about treatments provided at Iuvenis, including Botox, dermal fillers,  
6 and threadlifting, and he said he had no knowledge about these treatments. He further stated that  
7 he told C.F. to hire another physician to perform the physical exams and consultations. When  
8 asked whether C.F. obtained another physician, Respondent stated, “I don’t know if it was  
9 done.... It’s an error on my fault for trusting her to do the right thing, so -- and my  
10 communication with her has been very limited.”

11 17. C.F. continued practicing with an expired nursing license between August 2018 and  
12 May 2019.

13 18. Between 2018 and 2021, Iuvenis maintained medical records for Patients 2 through 7,  
14 who received Botox, Juvederm, facial fillers, threading, and laser hair removal. Iuvenis did not  
15 locate any records for Patient 1 because they reported that they had misplaced them.

16 a. Patient 2 received hydrafacial treatments and Botox injections from C.F. between  
17 February 2018 and June 2019. Respondent admitted that he did not know Patient  
18 2 and had never provided services to her. Nor did Respondent perform a physical  
19 examination or take Patient 2’s medical history, even though his stamped  
20 signature appeared on Patient 2’s medical records for a consultation.

21 b. Patient 3 received Botox, hydrafacial, and Juvederm treatments from C.F.  
22 between January 2018 and February 2019. Respondent admitted that he knew  
23 Patient 3 as a nurse with whom he worked at Natividad Medical Center in  
24 Salinas, he never saw Patient 3 as a patient, and his signature had been stamped  
25 for the consultation on her records without his knowledge.

26 c. Patient 4 received Botox injections, threading, and facials from C.F. between  
27 March 2018 and September 2021. Respondent admitted that he did not know  
28 Patient 4 and that he was unaware C.F. had provided Patient 4 with Botox

1 injections and dermal fillers. Respondent also admitted that he did not know  
2 Patient 4 had written 11 checks to C.F. while her nursing license was suspended.

3 d. Between March 2018 and February 2019, Patient 5 received threading from C.F.  
4 Respondent admitted that he knew Patient 5 and that he had worked with her at  
5 Natividad Hospital. Respondent did not treat Patient 5 as a patient and admitted  
6 that his signature had been stamped on Patient 5's records without his knowledge.

7 e. Patient 6 received Botox and derma fillers from C.F. in August 2018.  
8 Respondent's stamped signature appeared on Patient 6's medical records stating  
9 that he had performed a consultation on her. Respondent stated that he had not  
10 done this consultation.

11 f. Patient 7 received Botox and Juvederm injections and skin tag removal services  
12 from C.F. between July 2018 and December 2018. Respondent's stamped  
13 signature appeared on a consultation for threads and Botox for Patient 7.  
14 Respondent stated that he did not know Patient 7 or write on her medical records.

15 19. Under the standard of care, a licensed registered nurse is legally authorized to  
16 perform treatments with dermal fillers and neuromodulators and to operate laser treatments under  
17 a physician's supervision. However, Respondent admitted that C.F. treated patients at their  
18 jointly owned clinic, Iuvenis, without supervision and that he never examined any patient or  
19 signed a chart, and his stamped signature was used despite this. Based on these facts, Respondent  
20 committed an extreme departure from the standard of care.

21 20. Under the standard of care, Respondent, as the medical director, was responsible for  
22 establishing policies and procedures for the clinic, but there were none. He was also responsible  
23 for supervising the care and treatment of patients at the clinic and performing a good faith history  
24 and physical exam on every patient, but he failed to do so. Additionally, he allowed his signature  
25 stamp to be used on medical records of patients that he never examined or of whom he did not  
26 have knowledge.

27 21. Under the standard of care, a physician cannot practice outside of his education,  
28 training, experience, and competence. However, it is possible for any licensed physician to

1 obtain training and develop the expertise needed to own and operate a medical clinic providing  
2 the treatments given at Iuvenis and to supervise a registered nurse performing such treatments.  
3 Respondent admittedly did not possess the knowledge, education, training, or experience in any  
4 of the treatments provided at Iuvenis, and accordingly, Respondent committed an extreme  
5 departure from the standard of care.

6 **CAUSE FOR DISCIPLINE**

7 **(Unprofessional Conduct - Gross Negligence)**

8 22. The allegations set forth in Paragraphs 13 through 21 are incorporated by reference as  
9 if fully set forth therein.

10 23. By reason of the facts stated in Paragraphs 13 through 21, Respondent is subject to  
11 disciplinary action under sections 2234 (unprofessional conduct) and 2234(b) (gross negligence)  
12 of the Code. The circumstances are as follows:

- 13 a. Though Respondent jointly owned Iuvenis with C.F., a registered nurse,  
14 Respondent admittedly did not provide any services or treat any patients there.  
15 b. Respondent allowed C.F. to treat patients while unlicensed and without  
16 supervision at Iuvenis between 2018 and 2021.  
17 c. Respondent allowed his stamped signature to be used on the medical records of  
18 six patients that he never examined.  
19 d. Respondent did not possess the knowledge, education, training, and experience  
20 necessary to provide the treatments given at Iuvenis.

21 **PRAYER**

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

- 24 1. Revoking or suspending Physician's & Surgeon's Certificate Number A 82055,  
25 issued to Respondent Paul Richard Francisco, M.D.;
- 26 2. Revoking, suspending or denying approval of Respondent Paul Richard Francisco,  
27 M.D.'s authority to supervise physician assistants and advanced practice nurses;
- 28 3. Ordering Respondent Paul Richard Francisco, M.D., to pay the Board the costs of the

1 investigation and enforcement of this case, and if placed on probation, the costs of probation  
2 monitoring; and

3 4. Taking such other and further action as deemed necessary and proper.

4  
5 DATED: DEC 06 2024

JENIA JONES FOR  
REJI VARGHESE  
Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
*Complainant*

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