

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

**In the Matter of the Accusation Against: )**

**BASSETT H. BROWN, M.D. )**

**File No. 17-2000-105688**

**Physician's and Surgeon's )  
Certificate No. A 21064 )**

**Respondent. )**

**DECISION**

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

**This Decision shall become effective at 5:00 p.m. on September 2, 2004.**

**IT IS SO ORDERED August 3, 2004.**

**MEDICAL BOARD OF CALIFORNIA**

**By: Lorie G. Rice  
Lorie G. Rice, Chair  
Panel A  
Division of Medical Quality**

1 BILL LOCKYER, Attorney General  
of the State of California  
2 VLADIMIR SHALKEVICH, State Bar No. 203178  
Deputy Attorney General  
3 California Department of Justice  
300 So. Spring Street, Suite 1702  
4 Los Angeles, CA 90013  
Telephone: (213) 897-2148  
5 Facsimile: (213) 897-9395

6 Attorneys for Complainant

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

12 In the Matter of the Accusation Against:

13 BASSETT H. BROWN, M.D.  
14 P.O. Box 77287  
15 Los Angeles, California 90007

16 Physician and Surgeon Certificate No. A 21064

17 Respondent.

Case No. 17-2000-105688

OAH No. L2003030764

18 **STIPULATED SETTLEMENT AND**  
19 **DISCIPLINARY ORDER**

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. Ron Joseph (Complainant) is the Executive Director of the Medical Board  
24 of California. He brought this action solely in his official capacity and is represented in this matter  
25 by Bill Lockyer, Attorney General of the State of California, by Vladimir Shalkevich, Deputy  
26 Attorney General.

27 2. Respondent Bassett H. Brown, M.D. (Respondent) is represented in this  
28 proceeding by attorney J. Robert Liset, whose address is Miller & Holguin, 1801 Century Park  
East, 7th Fl., Los Angeles, CA 90067-2302.

3. On or about June 24, 1964, the Medical Board of California issued  
Physician and Surgeon Certificate No. A 21064 to Bassett H. Brown, M.D. (Respondent). The

1 Certificate was in full force and effect at all times relevant to the charges brought in Accusation  
2 No. 17-2000-105688 and will expire on April 30, 2005, unless renewed.

3 JURISDICTION

4 4. Accusation No. 17-2000-105688 was filed before the Division of Medical  
5 Quality (Division) for the Medical Board of California, Department of Consumer Affairs, and is  
6 currently pending against Respondent. The Accusation and all other statutorily required  
7 documents were properly served on Respondent on January 28, 2003. Respondent timely filed his  
8 Notice of Defense contesting the Accusation. A copy of Accusation No. 17-2000-105688 is  
9 attached as exhibit A and incorporated herein by reference.

10 ADVISEMENT AND WAIVERS

11 5. Respondent has carefully read, fully discussed with counsel, and  
12 understands the charges and allegations in Accusation No. 17-2000-105688. Respondent has also  
13 carefully read, fully discussed with counsel, and understands the effects of this Stipulated  
14 Settlement and Disciplinary Order.

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

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

24 CULPABILITY

25 8. Respondent admits that he is subject to disciplinary action under section  
26 2234, subdivision (a) in conjunction with subdivision (e) of the Code, as well as sections 651 and  
27 652 of the Code in that New Directions in Fertility, Inc, (New Directions) advertisements for the  
28 "Chapman Procedure" contained misleading claims and misrepresentations. Respondent directly

1 or indirectly made documents and advertisements through New Directions that misrepresented the  
2 existence of facts supporting the efficacy of the procedure, in violation of section 2234,  
3 subdivision (a) of the Code.

4 9. Respondent admits that he is subject to disciplinary action under section  
5 2234, subdivision (a) and 2286, in conjunction with sections 2400, 2406 and 2408 of the Code, as  
6 well as section 13401 and 13401.5 of the Corporations Code and section 1343 of title 16 of the  
7 California Code of Regulations, in that he violated the proscription against the corporate practice  
8 of medicine.

9 10. Respondent admits that he is subject to disciplinary action under section  
10 2234, subdivision (a), in conjunction with sections 2021, subdivision (c), 2272, 2285, 2286, 2407,  
11 and 2415 of the Code in that Respondent practiced medicine and advertised his infertility  
12 procedure under the name "New Directions in Fertility, Inc." without having a fictitious name  
13 permit from the board.

14 11. In mitigation, Respondent's structure of his business, his advertising  
15 practices and his failure to obtain authorization to use a fictitious business name from the Medical  
16 Board were based on incorrect advice provided to the respondent by legal counsel.

17 12. Respondent agrees that his Physician and Surgeon Certificate is subject to  
18 discipline and he agrees to be bound by the Division's imposition of discipline as set forth in the  
19 Disciplinary Order below.

#### 20 CONTINGENCY

21 13. This stipulation shall be subject to approval by the Division of Medical  
22 Quality. Respondent understands and agrees that counsel for Complainant and the staff of the  
23 Medical Board of California may communicate directly with the Division regarding this stipulation  
24 and settlement, without notice to or participation by Respondent or his counsel. By signing the  
25 stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek  
26 to rescind the stipulation prior to the time the Division considers and acts upon it. If the Division  
27 fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary  
28 Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal

1 action between the parties, and the Division shall not be disqualified from further action by having  
2 considered this matter.

3 14. The parties understand and agree that facsimile copies of this Stipulated  
4 Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same  
5 force and effect as the originals.

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

9 **DISCIPLINARY ORDER**

10 IT IS HEREBY ORDERED that Physician and Surgeon Certificate No. A 21064  
11 issued to Respondent Bassett H. Brown, M.D. is revoked. However, the revocation is stayed  
12 and Respondent is placed on probation for three (3) years on the following terms and conditions.

13  
14 1. **ETHICS COURSE** Within 60 calendar days of the effective date of this  
15 Decision, respondent shall enroll in a course in ethics, at respondent's expense, approved in  
16 advance by the Division or its designee. Failure to successfully complete the course during the  
17 first year of probation is a violation of probation.

18 An ethics course taken after the acts that gave rise to the charges in the  
19 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the  
20 Division or its designee, be accepted towards the fulfillment of this condition if the course would  
21 have been approved by the Division or its designee had the course been taken after the effective  
22 date of this Decision.

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

26 2. **RESTRICTED PRACTICE** During probation, respondent is prohibited  
27 from advertising or participating in advertising, in any manner, of any hydrotubation, or Chapman  
28 procedures. Any and all hydrotubation or Chapman procedures performed by the Respondent

1 while on probation shall be performed in a hospital only.

2 3. RESTITUTION Within 30 days of the effective date of this decision,  
3 Respondent shall provide restitution to three patients whose requests for a refund pursuant to a  
4 guarantee advertised by the Respondent were previously rejected. The restitution shall be in the  
5 amount of \$3,500.00 to each patient, T.T., I.T. and P.E.L. Respondent shall deliver proof to the  
6 Board or to its designee, showing that restitution was paid to these patients within 15 days after  
7 making said payment.

8 4. NOTIFICATION Prior to engaging in the practice of medicine, the  
9 respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or  
10 the Chief Executive Officer at every hospital where privileges or membership are extended to  
11 respondent, at any other facility where respondent engages in the practice of medicine, including  
12 all physician and locum tenens registries or other similar agencies, and to the Chief Executive  
13 Officer at every insurance carrier which extends malpractice insurance coverage to respondent.  
14 Respondent shall submit proof of compliance to the Division or its designee within 15 calendar  
15 days.

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

18 5. SUPERVISION OF PHYSICIAN ASSISTANTS During probation,  
19 respondent is prohibited from supervising physician assistants.

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

23 7. QUARTERLY DECLARATIONS Respondent shall submit quarterly  
24 declarations under penalty of perjury on forms provided by the Division, stating whether there has  
25 been compliance with all the conditions of probation. Respondent shall submit quarterly  
26 declarations not later than 10 calendar days after the end of the preceding quarter.

27 8. PROBATION UNIT COMPLIANCE Respondent shall comply with the  
28 Division's probation unit. Respondent shall, at all times, keep the Division informed of

1 respondent's business and residence addresses. Changes of such addresses shall be immediately  
2 communicated in writing to the Division or its designee. Under no circumstances shall a post  
3 office box serve as an address of record, except as allowed by Business and Professions Code  
4 section 2021(b).

5 Respondent shall not engage in the practice of medicine in respondent's place of  
6 residence. Respondent shall maintain a current and renewed California physician's and surgeon's  
7 license.

8 Respondent shall immediately inform the Division, or its designee, in writing, of  
9 travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last,  
10 more than 30 calendar days.

11 9. INTERVIEW WITH THE DIVISION, OR ITS DESIGNEE Respondent  
12 shall be available in person for interviews either at respondent's place of business or at the  
13 probation unit office, with the Division or its designee, upon request at various intervals, and  
14 either with or without prior notice throughout the term of probation.

15 10. RESIDING OR PRACTICING OUT-OF-STATE In the event  
16 respondent should leave the State of California to reside or to practice, respondent shall notify the  
17 Division or its designee in writing 30 calendar days prior to the dates of departure and return.  
18 Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is  
19 not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions  
20 Code.

21 All time spent in an intensive training program outside the State of California  
22 which has been approved by the Division or its designee shall be considered as time spent in the  
23 practice of medicine within the State. A Board-ordered suspension of practice shall not be  
24 considered as a period of non-practice. Periods of temporary or permanent residence or practice  
25 outside California will not apply to the reduction of the probationary term. Periods of temporary  
26 or permanent residence or practice outside California will relieve respondent of the responsibility  
27 to comply with the probationary terms and conditions with the exception of this condition and the  
28 following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and

1 Cost Recovery.

2 Respondent's license shall be automatically cancelled if respondent's periods of  
3 temporary or permanent residence or practice outside California total two years. However,  
4 respondent's license shall not be cancelled as long as respondent is residing and practicing  
5 medicine in another state of the United States and is on active probation with the medical  
6 licensing authority of that state, in which case the two year period shall begin on the date  
7 probation is completed or terminated in that state.

8 11. FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT

9 In the event respondent resides in the State of California and for any reason  
10 respondent stops practicing medicine in California, respondent shall notify the Division or its  
11 designee in writing within 30 calendar days prior to the dates of non-practice and return to  
12 practice. Any period of non-practice within California, as defined in this condition, will not apply  
13 to the reduction of the probationary term and does not relieve respondent of the responsibility to  
14 comply with the terms and conditions of probation. Non-practice is defined as any period of time  
15 exceeding 30 calendar days in which respondent is not engaging in any activities defined in  
16 sections 2051 and 2052 of the Business and Professions Code.

17 All time spent in an intensive training program which has been approved by the  
18 Division or its designee shall be considered time spent in the practice of medicine. For purposes  
19 of this condition, non-practice due to a Board-ordered suspension or in compliance with any other  
20 condition of probation, shall not be considered a period of non-practice.

21 Respondent's license shall be automatically cancelled if respondent resides in  
22 California and for a total of two years, fails to engage in California in any of the activities  
23 described in Business and Professions Code sections 2051 and 2052.

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

28 13. VIOLATION OF PROBATION Failure to fully comply with any term or



1 condition of probation is a violation of probation. If respondent violates probation in any respect,  
2 the Division, after giving respondent notice and the opportunity to be heard, may revoke  
3 probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to  
4 Revoke Probation, or an Interim Suspension Order is filed against respondent during probation,  
5 the Division shall have continuing jurisdiction until the matter is final, and the period of probation  
6 shall be extended until the matter is final.

7           14.    COST RECOVERY Within 90 calendar days, from the effective date of  
8 the Decision or other installment period agreed to by the Division or its designee, respondent shall  
9 reimburse the Division the amount of \$12,000.00 for its investigative and prosecution costs. The  
10 filing of bankruptcy or period of non-practice by respondent shall not relieve the respondent of his  
11 obligation to reimburse the Division for its costs.

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

23           16.    PROBATION MONITORING COSTS Respondent shall pay the costs  
24 associated with probation monitoring each and every year of probation, as designated by the  
25 Division, which are currently set at \$2,874.00, but may be adjusted on an annual basis. Such  
26 costs shall be payable to the Medical Board of California and delivered to the Division or its  
27 designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar  
28 days of the due date is a violation of probation.

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DATED: May 20<sup>th</sup> 2004

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DATED: May 20, 2004

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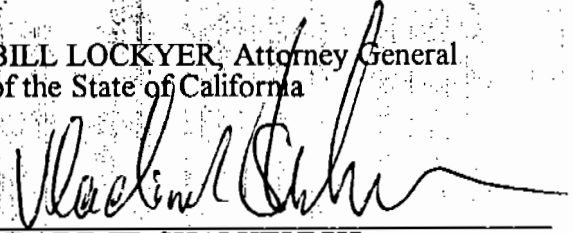
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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Division of Medical Quality, Medical Board of California of the Department of Consumer Affairs.

DATED: May 20, 2004

BILL LOCKYER, Attorney General  
of the State of California

  
VLADIMIR SHALKEVICH  
Deputy Attorney General

Attorneys for Complainant

DOJ Docket/Matter ID Number: 03573160-LA2002AD1058  
settlement agreement.wpd

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**Exhibit A**

**Accusation No. 17-2000-105688**

1 BILL LOCKYER, Attorney General  
of the State of California  
2 NANCY ANN STONER, State Bar No. 72839  
Deputy Attorney General, for  
3 MIA PEREZ-ARGOTE  
Deputy Attorney General  
4 California Department of Justice  
300 So. Spring Street, Suite 1702  
5 Los Angeles, CA 90013  
Telephone: (213) 897-7007  
6 Facsimile: (213) 897-1071  
7 Attorneys for Complainant

FILED  
STATE OF CALIFORNIA  
MEDICAL BOARD OF CALIFORNIA  
SACRAMENTO January 16, 2003  
BY Valerie M. Mearns ANALYST

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

12 In the Matter of the Accusation Against:

Case No. 17-2000-105688

13 BASSETT H. L. BROWN, M.D.  
P.O. Box 77287  
14 Los Angeles, California 90007

ACCUSATION

15 Physician and Surgeon Certificate No. A 21064

16 Respondent.  
17

18 Complainant alleges:

19 PARTIES

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

23 2. On or about June 25, 1964, the Medical Board of California issued  
24 Physician and Surgeon Certificate Number A 21064 to Bassett H. L. Brown, M.D. (Respondent).  
25 The Physician and Surgeon Certificate was in full force and effect at all times relevant to the  
26 charges brought herein and will expire on April 30, 2003, unless renewed.

27 JURISDICTION

28 3. This Accusation is brought before the Division of Medical Quality

1 (Division) for the Medical Board of California, Department of Consumer Affairs under the  
2 authority of the following statutes and regulations.<sup>1</sup>

3 4. Section 2227 of the Code states:

4 “(a) A licensee whose matter has been heard by an administrative law judge of the  
5 Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or  
6 whose default has been entered, and who is found guilty may, in accordance with the provisions  
7 of this chapter:

8 “(1) Have his or her license revoked upon order of the division.

9 “(2) Have his or her right to practice suspended for a period not to exceed one  
10 year upon order of the division.

11 “(3) Be placed on probation and be required to pay the costs of probation  
12 monitoring upon order of the division.

13 “(4) Be publicly reprimanded by the division.

14 “(5) Have any other action taken in relation to discipline as the division or an  
15 administrative law judge may deem proper.

16 “(b) Any matter heard pursuant to subdivision (a), except for warning letters,  
17 medical review or advisory conferences, or other matters made confidential or privileged by  
18 existing law, is deemed public, and shall be made available to the public by the board.”

19 5. Section 2234 of the Code states, in pertinent part:

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

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

25 “(b) Gross negligence.

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26  
27  
28 1. All statutory references are to the Business and Professions Code (Code) unless  
otherwise indicated.

1           “(c) Repeated negligent acts.

2           “(d) Incompetence.

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

5           “(f) Any action or conduct which would have warranted the denial of a  
6 certificate.”

7           6.       Section 651 of the Code states, in pertinent part:

8           “(a) It is unlawful for any person licensed under this division or under any  
9 initiative act referred to in this division to disseminate or cause to be disseminated, any form of  
10 public communication containing a false, fraudulent, misleading, or deceptive statement or  
11 claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of  
12 professional services or furnishing of products in connection with the professional practice or  
13 business for which he or she is licensed. A ‘public communication’ as used in this section  
14 includes, but is not limited to, communication by means of mail, television, radio, motion  
15 picture, newspaper, book, list or directory of healing arts practitioners, Internet, or other  
16 electronic communication.

17           “(b) A false, fraudulent, misleading, or deceptive statement, claim or image  
18 includes a statement or claim that does any of the following:

19           “(1) Contains a misrepresentation of fact.

20           “(2) Is likely to mislead or deceive because of a failure to disclose material facts.

21           “(3) (A) Is intended or is likely to create false or unjustified expectations of  
22 favorable results, including the use of any photograph or other image that does not accurately  
23 depict the results of the procedure being advertised or that has been altered in any manner from  
24 the image of the actual subject depicted in the photograph or image.

25           “ . . . .

26           “(4) Relates to fees, other than a standard consultation fee or a range of fees for  
27 specific types of services, without fully and specifically disclosing all variables and other  
28 material factors.

1           “(5) Contains other representations or implications that in reasonable probability  
2 will cause an ordinarily prudent person to misunderstand or be deceived.

3           “(6) Makes a claim either of professional superiority or of performing services in  
4 a superior manner, unless that claim is relevant to the service being performed and can be  
5 substantiated with objective scientific evidence.

6           “(7) Makes a scientific claim that cannot be substantiated by reliable, peer  
7 reviewed, published scientific studies.

8           “(8) Includes any statement, endorsement, or testimonial that is likely to mislead  
9 or deceive because of a failure to disclose material facts.

10           “(c) Any price advertisement shall be exact, without the use of such phrases,  
11 including, but not limited to, ‘as low as,’ ‘and up,’ ‘lowest prices’ or words or phrases of similar  
12 import. Any advertisement that refers to services, or costs for services, and that uses words of  
13 comparison shall be based on verifiable data substantiating the comparison. Any person so  
14 advertising shall be prepared to provide information sufficient to establish the accuracy of that  
15 comparison. Price advertising shall not be fraudulent, deceitful, or misleading, including  
16 statements or advertisements of bait, discount, premiums, gifts, or any statements of a similar  
17 nature. In connection with price advertising, the price for each product or service shall be clearly  
18 identifiable. The price advertised for products shall include charges for any related professional  
19 services, including dispensing and fitting services, unless the advertisement specifically and  
20 clearly indicates otherwise.

21           “ . . . .

22           “(e) Any person so licensed may not use any professional card, professional  
23 announcement card, office sign, letterhead, telephone directory listing, medical list, medical  
24 directory listing, or a similar professional notice or device if it includes a statement or claim that  
25 is false, fraudulent, misleading, or deceptive within the meaning of subdivision (b).

26           “ . . . .

27           “(g) Any violation of any provision of this section by a person so licensed shall  
28 constitute good cause for revocation or suspension of his or her license or other disciplinary



1 action.”

2 7. Section 652 of the Code states, in pertinent part:

3 “Violation of this article [Article 6, commencing with Section 650 of the Code] in  
4 the case of a licensed person constitutes unprofessional conduct and grounds for suspension or  
5 revocation of his or her license by the board by whom he or she is licensed, or if a license has  
6 been issued in connection with a place of business, then for the suspension or revocation of the  
7 place of business in connection with which the violation occurs. The proceedings for suspension  
8 or revocation shall be conducted in accordance with Chapter 5 (commencing with Section 11500)  
9 of Part 1 of Division 3 of Title 2 of the Government Code [the Administrative Procedure Act],  
10 and each board shall have all the powers granted therein.”

11 8. Section 725 of the Code states:

12 “Repeated acts of clearly excessive prescribing or administering of drugs or  
13 treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of  
14 clearly excessive use of diagnostic or treatment facilities as determined by the standard of the  
15 community of licensees is unprofessional conduct for a physician and surgeon.”

16 9. Section 2021 of the Code states, in pertinent part:

17 “(a) If the board publishes a directory pursuant to Section 112, it may require  
18 persons licensed pursuant to this chapter [Chapter 5, the Medical Practice Act] to furnish any  
19 information as it may deem necessary to enable it to compile the directory.

20 “. . . .

21 “(c) Each licensee shall report to the board each and every change of name within  
22 30 days after each change, giving both the old and new names.”

23 10. Section 2261 of the Code states:

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

27 11. Section 2264 of the Code states:

28 “The employing, directly or indirectly, the aiding, or the abetting of any

1 unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice  
2 of medicine or any other mode of treating the sick or afflicted which requires a license to practice  
3 constitutes unprofessional conduct.”

4           12.     Section 2266 of the Code states: “The failure of a physician and surgeon to  
5 maintain adequate and accurate records relating to the provision of services to their patients  
6 constitutes unprofessional conduct.”

7           13.     Section 2271 of the Code states: “Any advertising in violation of Section  
8 17500, relating to false or misleading advertising, constitutes unprofessional conduct.”

9           14.     Section 2272 of the Code states: “Any advertising of the practice of  
10 medicine in which the licensee fails to use his or her own name or approved fictitious name  
11 constitutes unprofessional conduct.”

12           15.     Section 2285 of the Code states:

13           “The use of any fictitious, false, or assumed name, or any name other than his or  
14 her own by a licensee either alone, in conjunction with a partnership or group, or as the name of a  
15 professional corporation, in any public communication, advertisement, sign, or announcement of  
16 his or her practice without a fictitious-name permit obtained pursuant to Section 2415 constitutes  
17 unprofessional conduct. This section shall not apply to licensees who contract with, are  
18 employed by, or are on the staff of, any clinic licensed by the State Department of Health  
19 Services under Chapter 1 (commencing with Section 1200) of Division 2 of the Health and  
20 Safety Code or any medical school approved by the division or a faculty practice plan connected  
21 with such a medical school.”

22           16.     Section 2286 of the Code states:

23           “It shall constitute unprofessional conduct for any licensee to violate, to attempt to  
24 violate, directly or indirectly, to assist in or abet the violation of, or to conspire to violate any  
25 provision or term of Article 18 (commencing with Section 2400), of the Moscone-Knox  
26 Professional Corporation Act (Part 4 commencing with Section 13400) of Division 3 of Title 1 of  
27 the Corporations Code), or of any rules and regulations duly adopted under those laws.”

28           17.     Section 2400 of the Code states:

1           “Corporations and other artificial legal entities shall have no professional rights,  
2 privileges, or powers. However, the Division of Licensing may in its discretion, after such  
3 investigation and review of such documentary evidence as it may require, and under regulations  
4 adopted by it, grant approval of the employment of licensees on a salary basis by licensed  
5 charitable institutions, foundations, or clinics, if no charge for professional services rendered  
6 patients is made by any such institution, foundation, or clinic.”

7           18.     Section 2406 of the Code states:

8           “A medical or podiatry corporation is a corporation which is authorized to render  
9 professional services, as defined in Sections 13401 and 13401.5 of the Corporations Code, so  
10 long as that corporation and its shareholders, officers, directors and employees rendering  
11 professional services who are physicians, psychologists, registered nurses, optometrists,  
12 podiatrists or, in the case of a medical corporation only, physician assistants, are in compliance  
13 with the Moscone-Knox Professional Corporation Act [Corporations Code section 13400 et  
14 seq.], the provisions of this article and all other statutes and regulations now or hereafter enacted  
15 or adopted pertaining to the corporation and the conduct of its affairs.

16           “With respect to a medical corporation or podiatry corporation, the governmental  
17 agency referred to in the Moscone-Knox Professional Corporation Act is the Division of  
18 Licensing.”

19           19.     Section 2407 of the Code states: “A medical or podiatry corporation shall  
20 be subject to the provisions of Sections 2285 and 2415.”

21           20.     Section 2410 of the Code states:

22           “A medical or podiatry corporation shall not do or fail to do any act the doing of  
23 which or the failure to do which would constitute unprofessional conduct under any statute or  
24 regulation now or hereafter in effect. In the conduct of its practice, it shall observe and be bound  
25 by such statutes and regulations to the same extent as a licensee under this chapter [Chapter 5,  
26 the Medical Practice Act].”

27           21.     Section 2415 of the Code states, in pertinent part:

28           “(a) Any physician and surgeon or any doctor of podiatric medicine, as the case

1 may be, who as a sole proprietor, or in a partnership, group, or professional corporation, desires  
2 to practice under any name that would otherwise be a violation of Section 2285 may practice  
3 under that name if the proprietor, partnership, group, or corporation obtains and maintains in  
4 current status a fictitious-name permit issued by the Division of Licensing, . . . under the  
5 provisions of this section.

6           “(b) The division or the board shall issue a fictitious-name permit authorizing the  
7 holder thereof to use the name specified in the permit in connection with his, her, or its practice if  
8 the division or the board finds to its satisfaction that:

9           “(1) The applicant or applicants or shareholders of the professional corporation  
10 hold valid and current licenses as physicians and surgeons . . . .

11           “(2) The professional practice of the applicant or applicants is wholly owned and  
12 entirely controlled by the applicant or applicants.

13           “(3) The name under which the applicant or applicants propose to practice is not  
14 deceptive, misleading, or confusing, and contains one of the following designations: ‘medical  
15 group,’ ‘medical clinic,’ ‘medical corporation,’ ‘medical associates,’ ‘medical center,’ or  
16 ‘medical office.’ . . .

17           “. . . .

18           “(e) The division or the board may revoke or suspend any permit issued if it finds  
19 that the holder or holders of the permit are not in compliance with the provisions of this section  
20 or any regulations adopted pursuant to this section. A proceeding to revoke or suspend a  
21 fictitious-name permit shall be conducted in accordance with Section 2230.

22           “(f) A fictitious-name permit issued to any licensee in a sole practice is  
23 automatically revoked in the event the licensee's certificate to practice medicine or podiatric  
24 medicine is revoked.”

25           22. Section 17200 of the Code provides, in part, that unfair competition  
26 includes “any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue  
27 or misleading advertising” and any act prohibited by Section 17500 *et seq.*

28           23. Section 17500 of the Code provides, in part:

1                    “It is unlawful for any person, firm, corporation or association, or any employee  
2 thereof with intent directly or indirectly . . . to perform services, professional or otherwise, . . . or  
3 to induce the public to enter into any obligation relating thereto, to make or disseminate or cause  
4 to be made or disseminated before the public in this state, or to make or disseminate or cause to  
5 be made or disseminate from this state before the public in any state, . . . any statement,  
6 concerning . . . those services, professional or otherwise, . . . which is untrue or misleading, and  
7 which is known, or which by the exercise of reasonable care should be known, to be untrue or  
8 misleading, or for any such person, firm, or corporation to so make or disseminate or cause to be  
9 so made or disseminated any such statement as part of a plan or scheme with the intent not to sell  
10 such personal property or services, professional or otherwise, so advertised at the price stated  
11 therein, or as so advertised. ”

12    Corporations Code:

13                    24.     Section 13401 of the Corporations Code states, in pertinent part:

14                    “As used in this part [Part 4, Moscone-Knox Professional Corporation Act]:

15                    “(a) ‘Professional services’ means any type of professional services that may be  
16 lawfully rendered only pursuant to a license, certification, or registration authorized by the  
17 Business and Professions Code. . . .

18                    “(b) ‘Professional corporation’ means a corporation organized under the General  
19 Corporation Law or pursuant to subdivision (b) of Section 13406 that is engaged in rendering  
20 professional services in a single profession, except as otherwise authorized in Section 13401.5,  
21 pursuant to a certificate of registration issued by the governmental agency regulating the  
22 profession . . . However, any professional corporation or foreign professional corporation  
23 rendering professional services by persons duly licensed by the Medical Board of California . . .  
24 shall not be required to obtain a certificate of registration in order to render those professional  
25 services.”

26                    25.     Section 13401.5 of the Corporations Code states, in pertinent part:

27                    “Notwithstanding subdivision (d) of Section 13401 and any other provision of  
28 law, the following licensed persons may be shareholders, officers, directors, or professional

1 employees of the professional corporations designated in this section so long as the sum of all  
2 shares owned by those licensed persons does not exceed 49 percent of the total number of shares  
3 of the professional corporation so designated herein, and so long as the number of those licensed  
4 persons owning shares in the professional corporation so designated herein does not exceed the  
5 number of persons licensed by the governmental agency regulating the designated professional  
6 corporation:

7                   “(a) Medical corporation.

8                   “(1) Licensed doctors of podiatric medicine.

9                   “(2) Licensed psychologists.

10                  “(3) Registered nurses.

11                  “(4) Licensed optometrists.

12                  “(5) Licensed marriage, family, and child counselors.

13                  “(6) Licensed clinical social workers.

14                  “(7) Licensed physician assistants.

15                  “(8) Licensed chiropractors.

16                  “(9) Licensed acupuncturists.”

17 California Code of Regulations:

18                   26.     Section 1343 of Title 16 of the California Code of Regulations states, in  
19 pertinent part:

20                   “A professional corporation shall comply with the following provisions:

21                   “(a) The corporation is organized and exists pursuant to the general corporation  
22 law and is a professional corporation within the meaning of the Moscone-Knox Professional  
23 Corporations Act (Corporations Code Section 13400 et seq.).

24                   “(b) Each shareholder, director or officer (except as provided in Section 13403 of  
25 the Corporations Code and Section 2408 of the code) holds a valid physician's and surgeon's  
26 certificate or certificate to practice podiatric medicine, as the case may be, provided that, a  
27 licensed podiatrist, psychologist, optometrist, physician's assistant, clinical social worker,  
28 marriage, family and child counselor, chiropractor or registered nurse may be a shareholder,

1 director or officer of a medical corporation so long as such licensed persons own no more than  
2 49% of the total shares issued by the medical corporation and the number of licensed persons  
3 owning shares in the medical corporation does not exceed the number of physicians owning  
4 shares in such a corporation.”

5 “. . . .

6 “(d) A physician and surgeon or podiatrist may be a shareholder, officer or  
7 director in more than one professional corporation.”

8 General Unprofessional Conduct:

9 27. Conduct which breaches the rules or ethical code of a profession or  
10 conduct which is unbecoming a member in good standing of a profession also constitutes  
11 unprofessional conduct. (*Shea v. Bd. of Medical Examiners*, (1978) 81 Cal.App.3d 564, 575.)

12 COST RECOVERY

13 28. Section 125.3 of the Code provides, in pertinent part, that the Division  
14 may request the administrative law judge to direct a licensee found to have committed a  
15 violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the  
16 investigation and enforcement of the case.

17 MEDI-CAL REIMBURSEMENT

18 29. Section 14124.12 of the Welfare and Institutions Code states, in part:

19 “(a) Upon receipt of written notice from the Medical Board of California, the  
20 Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a  
21 licensee's license has been placed on probation as a result of a disciplinary action, the department  
22 may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that  
23 gave rise to the probation, including any dental surgery or invasive procedure, that was  
24 performed by the licensee on or after the effective date of probation and until the termination of  
25 all probationary terms and conditions or until the probationary period has ended, whichever  
26 occurs first. This section shall apply except in any case in which the relevant licensing board  
27 determines that compelling circumstances warrant the continued reimbursement during the  
28 probationary period of any Medi-Cal claim, including any claim for dental services, as so

1 described. In such a case, the department shall continue to reimburse the licensee for all  
2 procedures, except for those invasive or surgical procedures for which the licensee was placed on  
3 probation.”

#### 4 FIRST CAUSE FOR DISCIPLINE

##### 5 (Gross Negligence)

6 30. Respondent is subject to disciplinary action under section 2234,  
7 subdivision (b) of the Code in that he was grossly negligent in his diagnosis, care and treatment  
8 of several patients who underwent the “Chapman procedure” he developed to treat infertility  
9 problems. The circumstances are as follows:

#### 10 Patient G.R.<sup>2</sup>

11 31. On or about January 20, 2000, Patient G.R. first saw Respondent because  
12 of her infertility problems. She completed a patient history form which indicated she had  
13 previous gynecological surgery, abnormal pap smear, chlamydia, pelvic inflammatory disease,  
14 difficulty becoming pregnant, and two prior tubal ectopic pregnancies. Respondent conducted a  
15 physical examination that date and, in his report, indicated the patient had two prior pregnancies  
16 and no ectopic pregnancies. Chlamydia and gonorrhea tests were ordered, but the results were  
17 not received that date. Respondent did not perform, or document, a rectal examination, pap  
18 smear, CBC count, chromotubation, hysterosalpingogram (HSG), laparoscopy, or pelvic  
19 ultrasound to confirm a tubal obstruction, and a recent sperm analysis of the partner was not  
20 obtained. Respondent diagnosed Patient G.R. as having tubal infertility caused by mid and distal  
21 tubal obstruction. The patient signed an “informed consent” form and Respondent performed the  
22 “Chapman Hydrotubation procedure” on her that day.<sup>3</sup> The procedure was completed at 2:30

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24 2. Initials are used in this pleading to protect patient privacy. Respondent will be  
25 provided with identifying information if discovery is requested.

26 3. Respondent claims the “Chapman Procedure” is a medical procedure he  
27 developed for treating tubal blockage and disease. In essence, Respondent injects an isotonic  
28 solution with an antibiotic through the cervix. The procedure is performed in a manner similar  
to other gynecological tests in which a gas (carbon dioxide) or a contrast media (used in the  
hysterosalpingogram (HSG) test) is injected to determine if it would pass through the uterine



1 p.m. The patient was sent home with two antibiotics, Flagyl and Doxycycline, and her spouse  
2 was given a prescription for Doxycycline.

3 32. Respondent performed a second "Chapman procedure" on Patient G.R. on  
4 or about February 4, 2000. The patient and her husband were given an antibiotic, Zithromax, and  
5 the patient also received a prescription for Tylenol #3 with codeine.

6 33. Respondent performed a third "Chapman procedure" on the patient on or  
7 about February 18, 2000. In addition to the premedication, the patient received a paracervical  
8 block. The procedure was completed at 5:00 p.m. and the last vital signs were taken at 2:30 p.m.  
9 The patient and her husband were given a prescription for the antibiotic Floxin.

10 In or about August 2000, Patient G.R. became pregnant.

11 34. The following acts and omissions in Respondent's care and treatment of  
12 Patient G.R., taken singularly or collectively, constituted gross negligence:

13 a. Respondent failed to perform or document a complete  
14 history and physical examination of the patient prior to diagnosing a tubal infertility  
15 caused by mid and distal tubal obstruction, and before performing the "Chapman  
16 procedure."

17 b. Respondent failed to obtain and review the surgical reports for the  
18 two previous ectopic pregnancies, he failed to obtain or review the report of the prior  
19 abnormal pap smear the patient noted, he did not request, perform or document a pap  
20 smear, and he did not request, review or document the results of a complete blood count  
21 (CBC).

22 c. Respondent failed to comply with his own protocol and the  
23 standards for an appropriate diagnostic work-up before approving the patient for the  
24 "Chapman procedure" in that he failed to obtain or review a recent sperm count of the  
25 spouse, he failed to perform or record a bimanual exam and/or a rectal exam, and he

26  
27 cavity and through the fallopian tubes. One of the known, positive side effects of the latter two  
28 tests was that the injected medium might cause the fallopian tubes to open, allowing pregnancy  
to take place.

1 failed to perform a chromotubation, HSG, laparoscopy, or pelvic ultrasound to confirm  
2 whether a tubal obstruction existed and to determine if the fertility procedure was  
3 medically indicated or appropriate.

4 d. Respondent ordered chlamydia and gonorrhea tests, but he did not  
5 wait for the results of the tests before proceeding with the operation.

6 e. Respondent stopped taking or recording the patient's vital signs  
7 before the third Chapman procedure was completed and the patient was discharged.  
8 Respondent also failed to note the time and condition of the patient when she was  
9 discharged.

10 f. Respondent prescribed multiple antibiotics to the patient and her  
11 husband without having or documenting a medical indication or reason for the different  
12 medications.

13 g. Respondent provided the patient with an Informed Consent form to  
14 sign that was inaccurate, incomplete and misleading. The form exaggerated the benefits  
15 and downplayed the dangers of the procedure. For example, it states the procedure "is  
16 hardly more invasive than a standard internal gynecological exam" and that there are no  
17 significant risk factors other than the very rare possibility of an allergic reaction to the  
18 drugs, a perforation or infection. The patient is not informed this is an invasive  
19 procedure that can cause a drop in blood pressure due to vagal reaction and can also cause  
20 or exacerbate pelvic inflammatory disease (PID). The Consent form also indicates the  
21 program requires an initial screening which includes, among other things, a complete  
22 history and recent laboratory analysis of the prospective father's semen, neither of which  
23 were required, performed or documented before this patient was diagnosed and approved  
24 for the procedure.

25 Patient S.A.

26 35. On or about May 25, 2000, Patient S.A. first saw Respondent because of  
27 her difficulty getting pregnant. She indicated on the patient history form that she had been taking  
28 diet medication for a long period of time. Respondent conducted a physical examination that

1 date and, in his report, noted the patient had been pregnant six times, had one birth, and 5  
2 therapeutic abortions. Chlamydia and gonorrhea tests were performed, but the results were not  
3 reported until May 30, 2000. Respondent did not perform, or document, a rectal examination,  
4 pap smear, CBC count, chromotubation, HSG, laparoscopy, or pelvic ultrasound to confirm a  
5 tubal obstruction. Respondent diagnosed Patient S.A. as having tubal infertility caused by mid  
6 and distal tubal obstruction. The patient signed an "informed consent" form and Respondent  
7 performed the "Chapman Hydrotubation procedure" on her that day. The last vital signs were  
8 taken and recorded at 11:40 a.m., and the procedure was completed at 12:08 p.m. The record  
9 does not indicate the time that the patient was discharged. The patient and her husband were  
10 given prescriptions for an antibiotic, Doxycycline.

11               36. Respondent performed a second "Chapman procedure" on Patient S.A. on  
12 or about June 5, 2000. The patient was discharged with two antibiotics, Flagyl and Zithromax.

13               37. A third "Chapman procedure" was performed on the patient on or about  
14 February 18, 2000. The operative form was signed by Respondent's partner, Dr. M. Cadry. The  
15 patient was discharged with a prescription for the antibiotic Floxin.

16               In or about July 2000, Patient S.A. became pregnant. However, she had a  
17 miscarriage months later.

18               38. The following acts and omissions in Respondent's care and treatment of  
19 Patient S.A., taken singularly or collectively, constituted gross negligence:

20                     a. Respondent failed to perform or document a complete  
21 history and physical examination of the patient prior to diagnosing a tubal infertility  
22 caused by mid and distal tubal obstruction, and before performing the "Chapman  
23 procedure."

24                     b. Respondent failed to request, perform or document a pap smear,  
25 and he did not request, review or document the results of a complete blood count (CBC).

26                     c. Respondent failed to comply with his own protocol and the  
27 standards for an appropriate diagnostic work-up before approving the patient for the  
28 "Chapman procedure" in that he failed to perform or record a bimanual exam and/or a

1 rectal exam, and he failed to perform a chromotubation, HSG, laparoscopy, or pelvic  
2 ultrasound to confirm whether a tubal obstruction existed and to determine if the fertility  
3 procedure was medically indicated or appropriate.

4 d. Respondent performed chlamydia and gonorrhea tests, but he did  
5 not wait for the results of the tests before proceeding with the operation.

6 e. Respondent stopped taking or recording the patient's vital signs  
7 before the first Chapman procedure was completed and the patient was discharged.  
8 Respondent also failed to note the time and condition of the patient when she was  
9 discharged.

10 f. Respondent prescribed multiple antibiotics to the patient and her  
11 husband without having or documenting a medical indication or reason for the different  
12 medications.

13 g. Respondent failed to obtain or note the name of the weight loss  
14 medication the patient had been taking for a long time, and he failed to consider or  
15 document the contraindications for taking such medication during pregnancy.

16 h. Respondent provided the patient with an Informed Consent form to  
17 sign that was inaccurate, incomplete and misleading. The form exaggerated the benefits  
18 and downplayed the dangers of the procedure. For example, it states the procedure "is  
19 hardly more invasive than a standard internal gynecological exam" and that there are no  
20 significant risk factors other than the very rare possibility of an allergic reaction to the  
21 drugs, a perforation or infection. The patient is not informed this is an invasive  
22 procedure that can cause a drop in blood pressure due to vagal reaction and can also cause  
23 or exacerbate pelvic inflammatory disease (PID). The Consent form also indicates the  
24 program requires an initial screening which includes, among other things, a complete  
25 history and physical exam which were not performed or documented before this patient  
26 was diagnosed and approved for the procedure.

27 Patient D.D.

28 39. On or about February 17, 2000, Patient D.D. first saw Respondent because

1 of her inability to get pregnant. She completed a patient history form which indicated she had a  
2 history of abnormal pap smears, condyloma (genital warts) removed with laser, and one prior  
3 tubal pregnancy. The patient's records also indicated she had a history of infertility due to tubal  
4 obstructions, cervical dysplasia (precancer or cancer of the cervix) treated with laser, and  
5 removal of a tubal pregnancy and right fimbrioplasty surgery, in 1999.

6           It is unclear from the record what, if any, physical examination was conducted  
7 prior to the "Chapman procedure" that was performed on March 17, 2000. Chlamydia and  
8 gonorrhea tests were taken on February 21, 2000, and the results were not reported until February  
9 24, 2000. The records do not indicate that a rectal examination, recent pap smear, or CBC count  
10 was conducted or documented. The patient's last tubal patency test performed one year earlier by  
11 another physician showed both tubes were open and clear after tubal pregnancy and other  
12 procedures were performed. A chromotubation, HSG, laparoscopy, or pelvic ultrasound was not  
13 conducted to confirm a tubal obstruction currently existed. The report of the husband's sperm  
14 analysis was two years old. Patient D.D. was diagnosed as having tubal infertility caused by mid  
15 and distal tubal obstruction. The patient signed an "informed consent" form and the "Chapman  
16 Hydrotubation procedure" was performed that same day. The last vital signs were taken and  
17 recorded around 4:25 p.m., and the procedure was completed at 5:15 p.m. The record does not  
18 indicate the time that the patient was discharged. The patient and her husband were given a  
19 prescription for an antibiotic, Doxycycline.

20           40.     Respondent performed a second "Chapman procedure" on Patient D.D. on  
21 or about March 2, 2000. The last vital signs were taken and recorded at 1:30 p.m., and the  
22 procedure was completed at 1:45 p.m. The record does not indicate the time that the patient was  
23 discharged. The patient was given another prescription for Doxycycline.

24           41.     Respondent performed a third "Chapman procedure" on the patient on or  
25 about March 10, 2000. In addition to the premedication, the patient received a paracervical  
26 block. The procedure was completed at 2:50 p.m. and the last vital signs were taken at 2:56 p.m.  
27 The patient and her husband were given a prescription for the antibiotic Floxin.

28           Patient D.D. became pregnant and had a miscarriage within 3 months of the

1 procedure. A HSG was conducted on or about June 29, 2001, which indicated the patient's tubes  
2 showed no evidence of an obstruction. Another "Chapman procedure" was not performed.

3 42. The following acts and omissions in Respondent's care and treatment of  
4 Patient D.D., taken singularly or collectively, constituted gross negligence:

5 a. Respondent failed to perform or document a complete  
6 history and physical examination of the patient prior to diagnosing a tubal infertility  
7 caused by mid and distal tubal obstruction, and before performing the "Chapman  
8 procedure."

9 b. Respondent failed to obtain and review any reports of the prior  
10 abnormal pap smears the patient noted, he did not request, perform or document a current  
11 pap smear despite the patient's history of cervical cancer or precancer, and he did not  
12 request, review or document the results of a complete blood count (CBC).

13 c. Respondent failed to comply with his own protocol and the  
14 standards for an appropriate diagnostic work-up before approving the patient for the  
15 "Chapman procedure" in that he failed to obtain or review a recent sperm analysis of the  
16 spouse conducted within the last 5 months, he failed to perform or record a bimanual  
17 exam and/or rectal exam, and he failed to perform a chromotubation, HSG, laparoscopy,  
18 or pelvic ultrasound to confirm whether a tubal obstruction existed and to determine if the  
19 fertility procedure was medically indicated or appropriate.

20 d. Chlamydia and gonorrhea tests were performed, but Respondent  
21 did not wait for the results before performing the first "Chapman procedure."

22 e. Respondent stopped taking or recording the patient's vital signs  
23 before the three Chapman procedures were completed and the patient was discharged.  
24 The time and condition of patient when discharged were not noted in the record.

25 f. Respondent prescribed multiple antibiotics to the patient and her  
26 husband without having or documenting a medical indication or reason for the different  
27 medications.

28 g. Respondent provided the patient with an Informed Consent form to

1 sign that was inaccurate, incomplete and misleading. The form exaggerated the benefits  
2 and downplayed the dangers of the procedure. For example, it states the procedure "is  
3 hardly more invasive than a standard internal gynecological exam" and that there are no  
4 significant risk factors other than the very rare possibility of an allergic reaction to the  
5 drugs, a perforation or infection. The patient is not informed this is an invasive  
6 procedure that can cause a drop in blood pressure due to vagal reaction and can also cause  
7 or exacerbate pelvic inflammatory disease (PID). The Consent form also indicates the  
8 program requires an initial screening which includes, among other things, a complete  
9 history and recent laboratory analysis of the prospective father's semen, neither of which  
10 were required, performed or documented before this patient was diagnosed and approved  
11 for the procedure.

12 Patient C.D.

13 43. On or about February 11, 2000, Patient C.D. saw Respondent because of  
14 her difficulty getting pregnant. She indicated on the patient history form that she had 2 children  
15 and 1 miscarriage or ectopic pregnancy. The patient's prior medical records, which had been  
16 sent to Respondent's office, showed the patient had a bilateral tubal ligation in 1991. The left  
17 fallopian tube had been reconstructed in 1998. She had a HSG in February 2, 1998 which showed  
18 significant stenosis of the reconstructed tube. A HSG performed on October 22, 1999, indicated  
19 amputation of both tubes and no contrast media was able to pass through.

20 Respondent conducted a physical examination on February 11<sup>th</sup> and, in his report,  
21 noted there had been a reversal of the bilateral tubal ligation and recurrent obstructions.  
22 Chlamydia and gonorrhea tests were performed, but the results were not reported until February  
23 17, 2000. Respondent did not perform, or document, a rectal examination, pap smear, CBC  
24 count, chromotubation, HSG, laparoscopy, or pelvic ultrasound to confirm a tubal obstruction or  
25 determine whether the tubal ligation and reconstruction adversely impacted the patient's ability  
26 to conceive at this point. Respondent diagnosed Patient C.D. as having tubal infertility caused by  
27 mid and distal tubal obstruction on a patient who had bilateral tubal ligation (BTL) followed by  
28 reconstruction and recurrent obstruction. The patient signed an "informed consent" form and

1 Respondent performed the "Chapman Hydrotubation procedure" on her that day. The last vital  
2 signs were taken and recorded at 4:10 p.m., and the procedure was completed at 4:00 p.m. The  
3 record does not indicate the time that the patient was discharged. The patient was given a  
4 prescription for an antibiotic, Doxycycline.

5 44. Respondent performed a second "Chapman procedure" on Patient C.D. on  
6 or about February 18, 2000. The last vital signs were taken at 12:55 p.m., but the procedure was  
7 not completed until 4:30 p.m. The record does not indicate the time or the condition of the  
8 patient when she was discharged. She was prescribed an antibiotic, Zithromax.

9 45. A third "Chapman procedure" was performed on the patient on or about  
10 March 3, 2000. The operative form was signed by Respondent's partner, Dr. M. Cadry. The  
11 patient and her spouse were given prescriptions for Floxin and Doxycycline.

12 In or about September 2000, another physician performed surgery on C.D. for an  
13 ectopic pregnancy.

14 46. On or about October 16, 2000, Respondent ordered a pelvic ultrasound  
15 which was read as normal, but recommended clinical correlation. Respondent performed a  
16 fourth "Chapman procedure" on Patient C.D. on or about October 16, 2000. There is no record  
17 of a clinical examination being conducted prior to the procedure. The surgery was completed at  
18 1:30 p.m. and the last vital signs were taken at 2:35 p.m. There is no indication in the record of  
19 the time and condition of the patient when she was discharged. She was given prescriptions for  
20 an antibiotic, Floxin and a pain medication with codeine, Tylenol #3.

21 47. The following acts and omissions in Respondent's care and treatment of  
22 Patient C.D., taken singularly or collectively, constituted gross negligence:

23 a. Respondent failed to perform or document a complete history and  
24 physical examination of the patient prior to diagnosing a tubal infertility caused by mid  
25 and distal tubal obstruction, and before performing the "Chapman procedure." He also  
26 failed to perform or document a complete re-examination of the patient before performing  
27 the fourth "Chapman procedure" in October, 2000, after the patient had another non-  
28 viable ectopic pregnancy and an ultrasound recommended clinical correlation of the



1 patient's condition.

2 b. Respondent failed to request, perform or document a pap smear,  
3 and he did not request, review or document the results of a complete blood count (CBC).

4 c. Respondent failed to comply with his own protocol and the  
5 standards for an appropriate diagnostic work-up before approving the patient for the  
6 "Chapman procedure" in that he failed to perform or record a bimanual exam and/or a  
7 rectal exam, and he failed to perform a chromotubation, HSG, laparoscopy, or pelvic  
8 ultrasound to confirm whether a tubal obstruction existed and to determine if the fertility  
9 procedures were medically indicated or appropriate in February and October, 2000.

10 d. Respondent performed chlamydia and gonorrhea tests, but he did  
11 not wait for the results of the tests before proceeding with the operation.

12 e. Respondent stopped taking or recording the patient's vital signs  
13 before the second Chapman procedure was completed. As to each procedure Respondent  
14 performed, Respondent failed to take or record vital signs until the patient was  
15 discharged. Respondent also failed to note the time and condition of the patient when she  
16 was discharged.

17 f. Respondent prescribed multiple antibiotics to the patient and her  
18 husband without having or documenting a medical indication or reason for the different  
19 medications.

20 g. Respondent provided the patient with an Informed Consent form to  
21 sign that was inaccurate, incomplete and misleading. The form exaggerated the benefits  
22 and downplayed the dangers of the procedure. For example, it states the procedure "is  
23 hardly more invasive than a standard internal gynecological exam" and that there are no  
24 significant risk factors other than the very rare possibility of an allergic reaction to the  
25 drugs, a perforation or infection. The patient is not informed this is an invasive  
26 procedure that can cause a drop in blood pressure due to vagal reaction and can also cause  
27 or exacerbate pelvic inflammatory disease (PID). The Consent form also indicates the  
28 program requires an initial screening which includes, among other things, a complete

1 history and physical exam which were not performed or documented before this patient  
2 was diagnosed and approved for the procedure.

3 Patient C.P.

4 48. On or about December 29, 2000, Patient C.P. saw Respondent because of  
5 her infertility problems. She completed a patient history form which indicated she had no  
6 pregnancies, an abnormal pap smear, possible endometriosis, in vitro fertilization, and currently  
7 taking medication, Zovirax, for genetic herpes. The patient also noted she had a reaction to  
8 anesthesia 15 years ago, but no further information was noted. Respondent conducted a physical  
9 examination that date. Chlamydia and gonorrhea tests were not ordered. Respondent did not  
10 perform, or document, a pap smear, CBC count, chromotubation, HSG, laparoscopy, or pelvic  
11 ultrasound to confirm a tubal obstruction, and a recent sperm analysis of the partner was not  
12 obtained. Respondent did not mark a diagnosis of tubal obstruction on his notes of the  
13 procedure. The patient signed an "informed consent" form and Respondent performed the  
14 "Chapman Hydrotubation procedure" on her that day. The procedure was completed at 4:00 p.m.  
15 The patient had moderate pain, vomited and was nauseous once, and had abdominal cramping  
16 pain during the procedure. She was sent home with an antibiotic, Doxycycline, and an analgesic,  
17 Motrin 600 mg. The time of discharge was not noted.

18 49. Respondent performed a second "Chapman procedure" on Patient C.P. on  
19 or about January 7, 2000. In addition to premedication, the patient received a paracervical block.  
20 The last vital sign was recorded at 11:50 a.m., and the procedure was completed at 1:30 p.m.  
21 The patient had moderately severe abdominal cramping pain and was nauseous during this  
22 procedure. She was sent home with an analgesic, Ibuprofen, but no antibiotic. The time of the  
23 discharge was not noted.

24 50. Respondent performed a third "Chapman procedure" on Patient C.P. on or  
25 about January 18, 2000. In addition to premedication, the patient received a paracervical block.  
26 The procedure was completed at 2:30 p.m. and the last vital signs were taken at 2:10 p.m. Again  
27 the patient suffered moderately severe abdominal cramping pain and nausea during this  
28 procedure. She was given two antibiotics, Zithromax and Flagyl, and a pain medication, Tylenol

1 #3 with codeine. Her husband was prescribed Zithromax. The time of discharge was not noted.

2 In or about April, 2000, Patient C.P. called to inform Respondent she was  
3 pregnant. There was no further notation about the pregnancy in the record, but Respondent  
4 explained the patient had two miscarriages attributed to hormonal imbalance. Additional  
5 procedures were performed.

6 51. Respondent performed a fourth "Chapman procedure" on patient C.P. on  
7 or about November 6, 2000. There is no indication in the record that Respondent performed a  
8 physical examination or obtained and reviewed records concerning the patient's intervening  
9 condition. In addition to premedication, the patient received a paracervical block. The patient  
10 tolerated the procedure poorly and suffered mild to moderate pain. The procedure was  
11 completed at 11:25 a.m. and the last vital signs were taken at 2:13 p.m. There is an illegible time  
12 of discharge noted around 2: 7 p.m. The patient was given the antibiotic Floxin.

13 52. Respondent performed a fifth "Chapman procedure" on Patient C.P. on or  
14 about November 17, 2000. In addition to premedication, the patient received a paracervical  
15 block. The procedure commenced at 10:20 a.m., but it was "interrupted" at 11:05 a.m. The only  
16 vital signs were taken at 9:16 a.m. Severe pain was noted. There is no further explanation about  
17 the course of the procedure or its termination prior to completion. The patient was discharged  
18 around 12:15 p.m.. No prescriptions or pain medications were noted.

19 In or about May, 2001, Patient C.P. called to inform Respondent she was  
20 pregnant. While the patient's survey indicated she was very pleased with the treatments, she did  
21 complain that Respondent needs to provide better pain medication or anesthesia. Respondent's  
22 clinic was not certified as an outpatient surgery center.

23 53. The following acts and omissions in Respondent's care and treatment of  
24 Patient C.P., taken singularly or collectively, constituted gross negligence:

25 a. Respondent failed to perform or document a complete history and  
26 physical examination of Patient C.P. prior to diagnosing a tubal infertility, and before  
27 performing the "Chapman procedure." He also failed to perform or document a complete  
28 re-examination of the patient before performing the fourth and fifth "Chapman

1 procedures" in November 2000, after the patient had two non-viable pregnancies that  
2 apparently terminated in miscarriages.

3 b. Respondent failed to obtain and review Patient C.P.'s prior medical  
4 records, including records describing her IVF and problem with anesthesia, he failed to  
5 obtain or review the report of the prior abnormal pap smear the patient noted, he did not  
6 request, perform or document a pap smear, and he did not request, review or document  
7 the results of a complete blood count (CBC). He also failed to obtain or review the  
8 records of the two pregnancies and apparent miscarriages the patient suffered before  
9 proceeding with the second set of "Chapman procedures" in November 2000, and he  
10 failed to test, determine or document the patient's hormonal condition which supposedly  
11 caused the miscarriages.

12 c. Respondent failed to comply with his own protocol and the  
13 standards for an appropriate diagnostic work-up before approving Patient C.P. for the  
14 "Chapman procedure" in that he failed to obtain or review a recent sperm count of the  
15 spouse, and he failed to perform a chromotubation, HSG, laparoscopy, or pelvic  
16 ultrasound to confirm whether a tubal obstruction existed and to determine if the fertility  
17 procedure was medically indicated or appropriate.

18 d. Respondent never ordered or documented the results of chlamydia  
19 and gonorrhea tests.

20 e. Respondent did not examine, test or document the condition of the  
21 patient's herpes. Respondent should not have been performed the procedure on a patient  
22 who was being treated for herpes.

23 f. Respondent stopped taking or recording Patient C.P.'s vital signs  
24 before the second, third and fifth Chapman procedures were completed and the patient  
25 was discharged. Respondent also failed to note the time and condition of the patient  
26 when she was discharged after the first three procedures.

27 g. Respondent prescribed multiple antibiotics to the patient without  
28 having or documenting a medical indication or reason for the different medications.

1 h. Respondent failed to adequately medicate or prescribe pain  
2 medications for Patient C.P., and he failed to prescribe or note in the record that the  
3 patient was given any pain medication after the fifth procedure which had to be  
4 interrupted.

5 i. Respondent provided Patient C.P. with an Informed Consent form  
6 to sign that was inaccurate, incomplete and misleading. The form exaggerated the  
7 benefits and downplayed the dangers of the procedure. For example, it states the  
8 procedure "is hardly more invasive than a standard internal gynecological exam" and that  
9 there are no significant risk factors other than the very rare possibility of an allergic  
10 reaction to the drugs, a perforation or infection. The patient is not informed this is an  
11 invasive procedure that can cause a drop in blood pressure due to vagal reaction and can  
12 also cause or exacerbate pelvic inflammatory disease (PID). The Consent form also  
13 indicates the program requires an initial screening which includes, among other things, a  
14 complete history and recent laboratory analysis of the prospective father's semen, neither  
15 of which were required, performed or documented before this patient was diagnosed and  
16 approved for the procedure.

17 Patient T.T.

18 54. In or about January 24, 2000, Patient T.T. saw Respondent because of her  
19 infertility problems. She completed a patient history form which indicated she had 1 child, 3  
20 miscarriages, abnormal pap smears, in vitro fertilizations, tubal surgeries, and pelvic  
21 inflammatory disease (PID). Medical records were obtained that showed a long history of  
22 infertility caused by fallopian tube disease, tubal reconstruction procedures, and unsuccessful in  
23 vitro fertilization. A history and physical examination was conducted on January 24, 2000.  
24 Chlamydia and gonorrhea tests were ordered. Respondent did not perform, or document, a pap  
25 smear, chromotubation, HSG, laparoscopy, or pelvic ultrasound to confirm a tubal obstruction,  
26 tubal dysfunction, or reparable tubal disease process. A rectal examination of the patient and  
27 recent sperm analysis of her husband were not ordered or documented. Respondent diagnosed  
28 mid and distal tubal obstruction. There is no "informed consent" form signed by the patient in

1 the record. Respondent performed the "Chapman Hydrotubation procedure" on Patient T.T. on  
2 January 24, 2000. The last vital signs were taken and reported at 1:30 p.m. and the procedure  
3 was completed at 2:00 p.m. The patient had moderate pain, was nauseous and vomited once  
4 during the procedure. She was sent home with two antibiotics, Zithromax and Flagyl and no pain  
5 medication or analgesic. The time of discharge was not noted.

6 55. Respondent performed a second "Chapman procedure" on Patient T.T. on  
7 or about February 4, 2000. The procedure was completed at 1:30 p.m. and the last vital signs  
8 were taken at 12:30 p.m. Patient T.T. was sent home with an antibiotic, Doxycycline. The time  
9 of discharge was not noted.

10 56. A third "Chapman procedure" was performed on Patient T.T. on or about  
11 February 17, 2000. The patient was premeditated and also received a paracervical block. The  
12 name of the medication(s) used for the block were not noted in the record. The procedure was  
13 completed at 12:45 p.m. and the last vital signs were taken at 12:05 p.m. Patient T.T. was  
14 discharged with an antibiotic, Floxin, and a second medication that is illegible. The time of  
15 discharge was not noted.

16 57. The patient's chlamydia and gonorrhea test results were reported on  
17 February 24, 2000, after all three procedures had been completed. Respondent never ordered any  
18 blood tests or CBC counts for Patient T.T. However, laboratory reports from Texas show that  
19 another physician ordered various blood tests, including CBC counts, on or about January 28,  
20 2000, February 2, 2000, and March 2, 2000. Patient T.T. had abnormal results in all three tests.  
21 Respondent did not document that he reviewed these abnormal blood test results or that there  
22 was any medical justification for performing the "Chapman procedures" despite these results.

23 58. Before deciding to undergo the "Chapman procedures," Patient T.T. had  
24 seen and heard advertisements by New Directions in Fertility that stated the first 100 patients at  
25 each NDIF location would receive a guarantee that NDIF would refund the patient's full \$3,500  
26 fee, or "if she prefers, provide her with another series of treatments free of charge," if the patient  
27 did not conceive within one year of receiving the procedure. Patient T.T. received a NDIF  
28 Guarantee certificate, dated December 15, 1999, and other correspondence confirming her

1 eligibility for the refund. The guarantee did not indicate there were any conditions that negated  
2 the refund. Over a year after the procedures were completed, Patient T.T. notified Respondent's  
3 office at NDIF that she had not become pregnant, and she requested a full refund of her money.  
4 On or about May 2, 2001, Mitchell Roth, as President of NDIF, sent a letter to Patient T.T.  
5 indicating the "Promotional Guarantee Refund Committee" denied her request for a refund  
6 because of her "failure to qualify under the medical conditions of the promotional guaranty."  
7 The letter specified Patient T.T. did not qualify because she "had tubal surgery and male factor  
8 infertility." The letter also stated that "after review of your records and after consultation with  
9 Dr. Brown, we are confident that your tubes were open as of 2/15/2000. Therefore it is likely  
10 you can conceive naturally." Respondent did not conduct a follow-up examination of Patient  
11 T.T.'s fallopian tubes after the procedures, therefore he had no clinical basis on which to claim  
12 that her tubes were open as of February 15, 2000. The letter also recommended that the patient's  
13 husband get a sperm test and take large doses of certain herbs.

14                   59.     The following acts and omissions in Respondent's care and treatment of  
15 Patient T.T., taken singularly or collectively, constituted gross negligence:

16                   a.     Respondent failed to perform or document a complete history and  
17 physical examination of the patient prior to diagnosing a tubal infertility, and before  
18 performing the "Chapman procedure."

19                   b.     Respondent obtained but failed to note that he reviewed the  
20 patient's prior medical records, including records describing her IVF procedures, tubal  
21 surgeries, fallopian tube disease, and abnormal pap smears and blood tests. He did not  
22 request, perform or document a pap smear, and he did not request, review or document  
23 the results of a complete blood count (CBC). Respondent failed to document a medical  
24 justification for proceeding with the "Chapman procedure," despite the fact that the  
25 patient's prior medical records showed abnormal results for these tests

26                   c.     Respondent failed to comply with his own protocol and the  
27 standards for an appropriate diagnostic work-up before approving the patient for the  
28 "Chapman procedure" in that he failed to obtain or review a recent sperm count of the

1 spouse, and he failed to perform a chromotubation, HSG, laparoscopy, or pelvic  
2 ultrasound to confirm whether a tubal obstruction, dysfunction, or irreparable disease  
3 process existed and to determine if the fertility procedure was medically indicated or  
4 appropriate.

5 d. Respondent ordered chlamydia and gonorrhea tests, but the failed  
6 to wait for the results before proceeding with all three of the treatments.

7 e. Respondent stopped taking or recording the patient's vital signs  
8 before the first, second, and third Chapman procedures were completed and the patient  
9 was discharged. Respondent also failed to note the time and condition of the patient  
10 when she was discharged after the procedures.

11 f. Respondent prescribed multiple antibiotics to Patient T.T. without  
12 having or documenting a medical indication or reason for the different medications.

13 g. Respondent failed to obtain the patient's informed consent or retain  
14 a signed document in her records.

15 h. Respondent advertised, and provided the patient with, a written  
16 guarantee that she would receive a full refund of the \$3,500 fee paid for the "Chapman  
17 procedures" if she did not get pregnant within one year. Respondent and his company,  
18 NDIF, Inc., failed to honor that guarantee when Patient T.T. requested her refund. The  
19 reasons given for denying the refund were false and had not been stated as requirements  
20 for the guarantee to apply. Respondent was aware of Patient T.T.'s tubal surgeries and he  
21 failed to follow his own protocol by not obtaining and reviewing a recent sperm analysis  
22 of the husband when he approved Patient T.T. for surgery and performed three "Chapman  
23 procedures" on her.

24 Patient I.T.

25 60. On or about January 10, 2000, Patient I.T. first saw Respondent because of  
26 her infertility problems. She had never been pregnant. She completed a patient history form  
27 which indicated she had gynecological surgery, abnormal pap smear, and chlamydia. She takes  
28 Advil or Ultram, a strong pain medication, for headaches and migraines. Prior medical records



1 were not obtained. A history and cursory physical examination was conducted by Respondent on  
2 January 10, 2000. Chlamydia and gonorrhea tests were not ordered. Respondent did not  
3 perform, or document, a pap smear, CBC blood test, chromotubation, HSG, laparoscopy, or  
4 pelvic ultrasound to confirm a tubal obstruction. A rectal examination of the patient and recent  
5 sperm analysis of her husband were not ordered or documented. Respondent did not note any  
6 classification of tubal obstruction on record of this patient's initial procedure. There is no  
7 "informed consent" form signed by the patient in the record. Respondent performed the  
8 "Chapman Hydrotubation procedure" on Patient I.T. on January 20, 2000. The last vital signs  
9 were taken and reported at 1:35 p.m. and the procedure was completed at 1:20 p.m. The patient  
10 experienced a lot of pain and discomfort during the procedure, but the records only reflect  
11 moderate pain, with nausea and vomiting. She was sent home with an antibiotic, Doxycycline  
12 and a pain medication, Tylenol #3 with codeine. The time of discharge was not noted.

13               61. A second "Chapman procedure" was performed on Patient I.T. on or about  
14 January 20, 2000. The record of this procedure was incomplete as there was no second page in  
15 the chart. The last vital signs were taken at 12:30 p.m., but there was no record of the time the  
16 procedure was completed, the time of discharge, and whether any prescriptions were given.

17               62. A third "Chapman procedure" was performed on Patient I.T. on or about  
18 February 11, 2000. The patient was premeditated and also received a paracervical block. The  
19 name of the medication(s) used for the block were not noted in the record. The patient described  
20 the procedure as "real painful," and she started to hemorrhage, but the record fails to indicate  
21 there was any bleeding and describes the pain as "moderate," even though the patient had nausea  
22 and vomited. The procedure was completed at 3:30 p.m. and the last vital signs were taken at  
23 2:15 p.m. Patient I.T. was discharged with an antibiotic, Floxin. The time of discharge was not  
24 noted.

25               63. Before deciding to undergo the "Chapman procedures," Patient I.T. had  
26 seen advertisements by New Directions in Fertility that stated the first 100 patients at each NDIF  
27 location would receive a guarantee that NDIF would refund the patient's full \$3,500 fee, or "if  
28 she prefers, provide her with another series of treatments free of charge," if the patient did not

1 conceive within one year of receiving the procedure. Patient I.T. received a NDIF Guarantee  
2 certificate, dated January 4, 2000, and other correspondence confirming her eligibility for the  
3 refund. The guarantee did not indicate there were any conditions that negated the refund. Over a  
4 year after the procedures were completed, Patient I.T. notified Respondent's office at NDIF that  
5 she had not become pregnant, and she requested a full refund of her money. On or about  
6 February 14, 2001, Mitchell W. Roth, as President of NDIF, sent a letter to Patient I.T. indicating  
7 the "Promotional Guarantee Refund Committee" would review her request for a refund and  
8 required them to sign a release of medical information from their health care providers. I.T.  
9 never received a response from the Committee or a refund of the fee.

10 64. The following acts and omissions in Respondent's care and treatment of  
11 Patient I.T., taken singularly or collectively, constituted gross negligence:

12 a. Respondent failed to perform or document a complete history and  
13 physical examination of the patient prior to diagnosing a tubal infertility, and before  
14 performing the "Chapman procedure."

15 b. Respondent failed to obtain or review Patient I.T.'s prior medical  
16 records, including records describing her gynecological surgery, abnormal pap smear, and  
17 chlamydia results. He did not request, perform or document a pap smear, a complete  
18 blood count (CBC), or chlamydia and gonorrhea tests. Respondent failed to document a  
19 medical justification for proceeding with the "Chapman procedure," despite the fact that  
20 the patient's prior medical history showed an abnormal pap smear and other  
21 gynecological complications.

22 c. Respondent failed to comply with his own protocol and the  
23 standards for an appropriate diagnostic work-up before approving Patient I.T. for the  
24 "Chapman procedure" in that he failed to obtain or review a recent sperm count of her  
25 spouse, and he failed to perform a chromotubation, HSG, laparoscopy, or pelvic  
26 ultrasound to confirm whether a tubal obstruction existed and to determine if the fertility  
27 procedure was medically indicated or appropriate.

28 d. Respondent stopped taking or recording Patient I.T.'s vital signs

1 before completing the third Chapman procedures and the patient was discharged.

2 Respondent also failed to note the time and condition of the patient when she was  
3 discharged after the three procedures.

4 e. Respondent prescribed multiple antibiotics to Patient I.T. without  
5 having or documenting a medical indication or reason for the different medications.

6 f. Respondent failed to obtain the patient's informed consent or retain  
7 a signed document in her records.

8 g. Respondent advertised, and provided the patient with, a written  
9 guarantee that she would receive a full refund of the \$3,500 fee paid for the "Chapman  
10 procedures" if she did not get pregnant within one year. Respondent and his company,  
11 NDIF, Inc., failed to honor that guarantee when Patient I.T. requested her refund. No  
12 reasons were given for denying the refund. The requirement that Patient I.T. authorize a  
13 release and review of her medical records had not been stated as prerequisite for the  
14 guarantee.

## 15 SECOND CAUSE FOR DISCIPLINE

### 16 (Repeated Negligent Acts)

17 65. Respondent is subject to disciplinary action under section 2234,  
18 subdivision (c) of the Code in that he was repeatedly negligent in his diagnosis, care and  
19 treatment of several patients who underwent the "Chapman procedure" he developed to treat  
20 infertility problems. The circumstances are as follows:

21 66. The facts and allegation set forth in paragraphs 30 through 64 above are  
22 incorporated here by reference.

23 67. The following acts and omissions in Respondent's care and treatment of  
24 Patients G.R., S.A., D.D., C.D., C.P., T.T., and I.T., taken singularly or collectively, constituted  
25 repeated negligence:

26 a. Respondent failed to perform or document complete histories and  
27 physical examinations of the patients prior to diagnosing tubal infertility and before  
28 performing the "Chapman procedure."

1                   b.       Respondent failed to obtain and review the patients' pertinent  
2 medical and surgical reports, he failed to obtain or review reports of prior abnormal pap  
3 smears, he did not request, perform or document pap smear for the patients, and he did  
4 not request, review or document the results of complete blood counts (CBC).

5                   c.       Respondent failed to comply with his own protocol and the  
6 standards for an appropriate diagnostic work-up before approving the patients for the  
7 "Chapman procedure" in that he failed to obtain or review a recent sperm count of the  
8 spouse, he failed to perform or record a bimanual exam and/or a rectal exam, and he  
9 failed to perform a chromotubation, HSG, laparoscopy, or pelvic ultrasound to confirm  
10 whether a tubal obstruction existed and to determine if the fertility procedure was  
11 medically indicated or appropriate.

12                  d.       Respondent failed to obtain or note the name of the weight loss  
13 medication that Patient S.A. had been taking for a long time, and he failed to consider or  
14 document the contraindications for taking such medication during pregnancy.

15                  e.       Respondent failed to perform or document a complete re-  
16 examination of Patients C.D. and C.P. before performing a second series of "Chapman  
17 procedures" after the patients had non-viable pregnancies. He failed to obtain or review  
18 the pertinent medical records of the terminated pregnancies before proceeding with the  
19 additional procedure.

20                  f.       Respondent ordered chlamydia and gonorrhea tests for the patients,  
21 but he did not wait for the results of the tests before proceeding with their operations. As  
22 to Patient C.P., Respondent never ordered or documented the results of chlamydia and  
23 gonorrhea tests before performing five "Chapman procedures."

24                  g.       Respondent did not examine, test or document the condition of the  
25 Patient C.P.'s herpes. Respondent should not have been performed the procedure on a  
26 patient who was being treated for herpes.

27                  h.       Respondent failed to adequately medicate or prescribe pain  
28 medications for Patient C.P., and he failed to prescribe or note in the record that the

1 patient was given any pain medication after the fifth procedure which had to be  
2 interrupted.

3 i. Respondent stopped taking or recording the patients' vital signs  
4 before the Chapman procedures were completed and the patients were discharged.  
5 Respondent also failed to note the time and condition of the patients when they were  
6 discharged.

7 j. Respondent prescribed multiple antibiotics to the patients and their  
8 husbands without having or documenting a medical indication or reason for the different  
9 medications.

10 k. Respondent provided the patients with an Informed Consent form  
11 to sign that was inaccurate, incomplete and misleading. The form exaggerated the  
12 benefits and downplayed the dangers of the procedure. For example, it stated the  
13 procedure "is hardly more invasive than a standard internal gynecological exam" and that  
14 there are no significant risk factors other than the very rare possibility of an allergic  
15 reaction to the drugs, a perforation or infection. The patients were not informed this is an  
16 invasive procedure that can cause a drop in blood pressure due to vagal reaction and can  
17 also cause or exacerbate pelvic inflammatory disease (PID). The Consent form also  
18 indicated the program requires an initial screening which includes, among other things, a  
19 complete history and recent laboratory analysis of the prospective father's semen, neither  
20 of which were required, performed or documented before the patients were diagnosed and  
21 approved for the procedures.

22 l. Respondent failed to obtain informed consent from Patients T.T.  
23 and I.T, and he did not retain a signed document in their records.

24 m. Respondent advertised, and provided Patients T.T. and I.T. with, a  
25 written guarantee that they would receive a full refund of the \$3,500 fee paid for the  
26 "Chapman procedures" if they did not get pregnant within one year. Respondent and his  
27 company, NDIF, Inc., failed to honor that guarantee when Patients T.T. and I.T. requested  
28 a refund. The reasons given for denying T.T.'s refund were false and had not been stated

1 as requirements for the guarantee to apply. Respondent was aware of Patient T.T.'s tubal  
2 surgeries and he failed to follow his own protocol by not obtaining and reviewing a recent  
3 sperm analysis of the husband when he approved Patient T.T. for surgery and performed  
4 three "Chapman procedures" on her. Respondent conducted no follow-up examination of  
5 Patient T.T.'s fallopian tubes after the procedures, therefore he had no clinical basis on  
6 which to claim in the denial letter that her tubes were open as of February 15, 2000,

7 THIRD CAUSE FOR DISCIPLINE

8 (Incompetence)

9 68. Respondent is subject to disciplinary action under section 2234,  
10 subdivision (d) of the Code in that he was incompetent in his diagnosis, care and treatment of  
11 several patients who underwent the "Chapman procedure" he developed to treat infertility  
12 problems. The circumstances are as follows:

13 69. The facts and allegation set forth in paragraphs 30 through 67 above are  
14 incorporated here by reference.

15 FOURTH CAUSE FOR DISCIPLINE

16 (Dishonesty and Misleading Advertising)

17 70. Respondent is subject to disciplinary action under section 2234,  
18 subdivision (a) in conjunction with subdivision (e) of the Code, as well as sections 651, 652,  
19 2271, 2272, 17200, and 17500 of the Code in that Respondent's advertisements for the  
20 "Chapman Procedure" contained false and misleading claims and representations. Respondent  
21 directly or indirectly made documents and advertisements that falsely represented the existence  
22 of facts supporting the efficacy of the procedure, in violation of sections 2234, subdivision (a)  
23 and 2262 of the Code. The circumstances are as follows:

24 71. The facts and allegations set forth in paragraphs 30 through 67 above are  
25 incorporated here by reference.

26 72. Commencing in or about July, 1999, Respondent formed a corporation  
27 with an unlicensed person, Mitchell W. Roth, entitled "New Directions in Fertility" [NDIF].  
28 Respondent was the Medical Director of NDIF. He held himself out as practicing medicine at

1 NDIF, and, in particular provided fertility treatments he developed, called the "Chapman  
2 procedure." New Directions in Fertility [NDIF] did not apply for and was never granted a  
3 fictitious name permit from the Medical Board of California.

4 73. Respondent directly and indirectly, with the assistance of others,  
5 advertised his services, and the benefits of the "Chapman procedure," over the NDIF Internet  
6 web site and on video tapes that were available to interested consumers.

7 74. Respondent's advertisements, through NDIF, contained false, misleading  
8 and deceptive statements and claims that were intended to induce people to obtain professional  
9 infertility treatments from Respondent and his company. The statements and claims  
10 misrepresented facts, failed to disclose material information, and created false or unjustified  
11 expectations of favorable results.

12 75. Some of the false and misleading statements and claims in Respondent's  
13 advertisements include, but are not necessarily limited to, the following:

14 a. "Our clinical experience has convinced us that our procedure is  
15 effective in restoring tubal health and function in all these cases [of blocked or  
16 dysfunctional fallopian tubes]." Respondent did not maintain statistics of the success rate  
17 of the procedure, and he indicated it would be difficult to locate records that would  
18 corroborate the occurrence of pregnancy. As the patient cases set forth above indicate,  
19 most of the pregnancies that occurred after the "Chapman procedure" did not remain  
20 viable and did not result in live births.

21 b. "There are no significant risks of core complications from the  
22 procedure, other than a remote possibility of an allergic reaction - and patients are  
23 screened for medical allergies prior to the procedure." As indicated above, this is an  
24 invasive procedure that can cause a drop in blood pressure due to vagal reaction and can  
25 also cause or exacerbate pelvic inflammatory disease (PID), and patients receive a  
26 minimal examination and are not screened. prior to the procedure.

27 c. "Dr. Brown has done an exhaustive search of the medical  
28 literature, and, as far as we can tell, no one else has performed this procedure. Nor is

1 there any suggestion of a similar procedure to be found.” As indicated above, the  
2 “Chapman procedure” is performed in a manner similar to other gynecological tests in  
3 which a gas (carbon dioxide) or a contrast media (used in the HSG test) is injected to  
4 determine if it would pass through the uterine cavity and through the fallopian tubes. One  
5 of the known, positive side effects of the latter two tests was that the injected medium  
6 might cause the fallopian tubes to open, allowing pregnancy to take place. Respondent is  
7 aware that the procedure is used in other places to treat infertility.

8 d. “Once we’ve filtered out those patients with likely problems  
9 unrelated to the fallopian tubes disease, we expect a better than 80% success rate from  
10 our procedure. . . . nearly all [of Respondent’s patients] became pregnant within two or  
11 three months of completion of the procedure.” Respondent does not keep statistics of his  
12 success rate, he does not conduct tests before or after the procedure to determine what, if  
13 any change in the fallopian tubes has occurred, and he does not adequately examine or  
14 screen his patients to determine the cause of their fertility difficulties, as is more fully set  
15 forth above.

16 e. “Of the patients treated by our licensed physicians since December  
17 28, 1999 to date, who have hydrosalpinx [tube obstructed and full of liquid], all have  
18 demonstrably opened and cleared except one patient.” Respondent claimed to be able to  
19 document one case in which the patient had hydrosalpinx and pregnancy occurred after  
20 the procedure was performed. Of the 50 other patients recently treated for hydrosalpinx,  
21 Respondent had no results available.

22 f. In the video taped advertisement, another doctor states “This  
23 procedure has worked on patients with a problem of tubal infertility. It’s had greater  
24 success than one can anticipate using any other treatment whether it’s surgical or non-  
25 surgical.” Respondent had no statistical information to support this claim and he did not  
26 provide any studies that compared the success rate of the “Chapman procedure” to other  
27 fertility treatments, the gas insufflation method, or the HSG. Respondent had no  
28 objective scientific evidence to substantiate the superiority of this procedure.



1 g. Respondent had no reliable, peer reviewed, published scientific  
2 studies to support any of the above claims and statements.

3 76. Respondent also claimed through advertisements by New Directions in  
4 Fertility that the first 100 patients at each NDIF location guaranteed a refund the patient's full  
5 \$3,500 fee, or "if she prefers, provide her with another series of treatments free of charge," if the  
6 patient did not conceive within one year of receiving the procedure. The advertised guarantees  
7 were false, misleading and failed to disclose all variables and other material factors that affected  
8 the full price refund, in violation of sections 651, subdivisions (b) (4), and (c) of the Code. The  
9 circumstances are as follows:

10 a. The guarantee did not indicate there were any conditions that  
11 negated the refund. Patients who notified Respondent's office at NDIF that they did not  
12 become pregnant were denied the full refund based on requirements that were not set  
13 forth in the guarantee.

14 b. False reasons were given to deny the requested refunds, including  
15 claims that the patients did not qualify due to a pre-existing medical condition which  
16 Respondent either knew, or should have known about when he had conducted the history  
17 and physical examinations of the patients and approved them for surgery.

18 c. Refund requests were also falsely denied based on Respondent's  
19 unsubstantiated assertion that the patient's tubes were open after the procedure when, in  
20 Respondent did not conduct a follow-up examination after the procedures, and therefore  
21 he had no clinical basis on which to base such a claim.

22 d. The advertisements and guarantee deceived and misled patients  
23 about the price of Respondent's treatments, the financial and medical risks they were  
24 taking, and the discount or rebate they would receive if the procedures did not result in  
25 pregnancy.

26 FIFTH CAUSE FOR DISCIPLINE

27 (Aiding and Abetting Unlicensed Practice of Medicine)

28 77. Respondent is subject to disciplinary action under sections 2234,

1 subdivision (a) and 2286, in conjunction with sections 2400, 2406, and 2408 of the Code, as well  
2 as sections 13401 and 13401.5 of the Corporations Code, and section 1343 of Title 16 of the  
3 California Code of Regulations, in that he aided and abetted the unlicensed practice of medicine  
4 performed by New Directions in Fertility, Inc. The circumstances are as follows:

5 a. The facts and allegations set forth in paragraphs 30 through 67, and  
6 70 through 76 above are incorporated here.

7 b. In or about July, 1999, New Directions in Fertility, Inc. [NDIF,  
8 Inc.] filed Articles of Incorporation with the Secretary of State to obtain corporate status.  
9 Mitchell W. Roth is listed as the President of the corporation. On or about October 29,  
10 1999, a "Statement by Domestic Stock Corporation" was filed with the Secretary of State  
11 on behalf of NDIF, Inc., by Mitchell W. Roth, the Chief Executive Officer. The type of  
12 business was designated "Specialized Infertility Clinics." The Directors of the  
13 Corporation were listed as Mitchell W. Roth, Bassett H. L. Brown, M.D., and Victoria  
14 Poole-Roth. Mitchell Roth and Victoria Poole-Roth are not licensed in California as  
15 physicians and surgeons; their positions in NDIF, Inc., violated sections 2406 and 2408 of  
16 the Code.

17 c. Respondent estimated that he owned about 40 percent of the stock  
18 in NDIF, Inc.; he had a certificate, dated July 20, 1999, for 250,000 shares of common  
19 stock which he jointly owned with Marcela Brown, who is not licensed as a physician  
20 and surgeon in California. The majority if the shares in the corporation were owned by  
21 Mitchell Roth and other investors who were not licensed as physicians and surgeons in  
22 California, in violation of section 2408 of the Code, section and 13401.4, subdivision (a)  
23 of the Corporations Code, and section 1343 of Title 16 of the California Code of  
24 Regulations.

25 d. NDIF, Inc., was, and held itself out as, the owner of a proprietary  
26 procedure for the non-surgical treatment of fallopian tube infertility. The corporation  
27 claimed to license the use of the "Chapman procedure," purportedly developed by  
28 Respondent, to carefully selected physicians who commit to limiting their practice.

1 NDIF, Inc. contracts with these physicians to manage their medical practices.

2 SIXTH CAUSE FOR DISCIPLINE

3 (Practiced Under Fictitious Name Without a Permit)

4 78. Respondent is subject to disciplinary action under sections 2234,  
5 subdivision (a), in conjunction with sections 2021, subdivision (c), 2272, 2285, 2286, 2407, and  
6 2415 of the Code in that Respondent practiced medicine, and advertised his infertility procedure  
7 under the name "New Directions in Fertility, Inc." without having a fictitious name permit from  
8 the board. The circumstances are as follows:

9 a. The facts and allegations set forth in paragraphs 30 through 67, and  
10 70 through 77 above are incorporated here by reference.

11 b. Respondent was issued a physician and surgeon certificate under  
12 the name of Bassett H.L. Brown, M.D.

13 c. Respondent practiced medicine and advertised his infertility  
14 treatments through a corporation entitled "New Directions in Fertility, Inc."

15 d. Respondent never obtained a fictitious name permit from the  
16 Medical Board to practice under the name "New Directions in Fertility, Inc." or "New  
17 Directions in Fertility Medical Group."

18 e. Respondent never reported to the Medical Board that he changed  
19 the name under which he was practicing medicine, and holding himself out to practice  
20 medicine under the name of the corporation "New Directions in Fertility."

21 f. The entities "New Directions in Fertility, Inc." and "New  
22 Directions in Fertility Medical Group" did not have a fictitious name permit from the  
23 Medical Board to practice medicine or to offer medical and infertility services in  
24 California. "New Directions in Fertility Medical Group" is not incorporated by the  
25 Secretary of State to do business in California.

26 g. New Directions in Fertility, Inc., did not include the designation  
27 "medical group, "medical corporation" or any other designation required by section 2415,  
28 subdivision (b)(3) of the Code.

1 SEVENTH CAUSE FOR DISCIPLINE

2 (Failure to Maintain Adequate Records)

3 79. Respondent is subject to disciplinary action under sections 2234,  
4 subdivision (a), in conjunction with 2266 of the Code in that he failed to maintain accurate and  
5 complete medical records of the treatment he rendered to several patients with infertility  
6 problems. The circumstances are as follows:

7 a. The facts and allegations set forth in paragraphs 30 through 67 and  
8 70 through 78 above are incorporated here.

9 b. Respondent failed to maintain records documenting: that thorough  
10 and appropriate history and physical examination had been conducted; that pertinent  
11 medical, gynecological and surgical records had been obtained and reviewed; that  
12 appropriate diagnostic tests had been ordered and the results reviewed prior to diagnosing  
13 the patients' conditions and determining that the "Chapman procedure" was medically  
14 indicated; that the patients' vital signs and condition throughout the procedure until  
15 discharge were accurately determined and recorded; and that his own protocol and the  
16 standards of care for infertility patients had been followed, as is more fully set forth  
17 above.

18 c. Respondent also failed to maintain records documenting: the  
19 results of his procedures; the condition of the patients' fallopian tubes before or after the  
20 procedure; whether the procedure had been "successful," whether and when the patient  
21 became pregnant, whether the pregnancy remained viable or terminated; and other  
22 statistical information to support his claims of success and comparing the success rate of  
23 the "Chapman procedure" to other fertility treatments or HSG.

24 EIGHTH CAUSE FOR DISCIPLINE

25 (Excessive Infertility Procedures)

26 80. Respondent is subject to disciplinary action under section 725 of the Code  
27 in that he excessively prescribed and performed infertilization procedures on several patients.  
28 The circumstances are as follows:

1 a. The facts and allegations set forth in paragraphs 30 through 67, and  
2 70 through 79 above are incorporated here.

3 b. Respondent diagnosed tubal obstructions and performed the  
4 "Chapman Infertility procedure" on Patients G.R., S.A., D.D., C.D., C.P., T.T, and I.T.,  
5 without first conducting a thorough and appropriate history and physical examination,  
6 obtaining pertinent medical, gynecological and surgical records, ordering appropriate  
7 diagnostic tests and reviewing the results reviewed prior to diagnosing the patients'  
8 conditions and determining that the "Chapman procedure" was medically indicated, as is  
9 more fully set forth above.

10 c. Respondent conducted cursory and inadequate histories and  
11 physical examinations, repeatedly arrived at the same diagnosis, and performed the same  
12 infertility procedure regardless of the patients' condition and gynecological history.  
13

14 PRAYER

15 WHEREFORE, Complainant requests that a hearing be held on the matters herein  
16 alleged, and that following the hearing, the Division of Medical Quality issue a decision:

17 1. Revoking or suspending Physician and Surgeon Certificate Number A  
18 21064, issued to Bassett H. L. Brown, M.D.;

19 2. Revoking, suspending or denying approval of Bassett H. L. Brown, M.D.'s  
20 authority to supervise physician's assistants, pursuant to section 3527 of the Code;

21 3. Ordering Bassett H. L. Brown, M.D. to pay the Division of Medical  
22 Quality the reasonable costs of the investigation and enforcement of this case, and, if placed on  
23 probation, the costs of probation monitoring;

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

DATED: January 16, 2003

  
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RON JOSEPH  
Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
Complainant

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