Complainant alleges:

PARTIES

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

2. On or about December 17, 1990, the Medical Board issued Physician's and Surgeon's Certificate Number G70489 to Leonard Sunil Kurian, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2016, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.
4. Section 2229 of the Code states, in subdivision (a):

“Protection of the public shall be the highest priority for the Division of Medical Quality,\(^1\) the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.”

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

6. Section 2234 of the Code, states:

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

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

“(b) Gross negligence.

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

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

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

“(d) Incompetence.

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\(^1\) Pursuant to Business and Professions Code section 2002, the “Division of Medical Quality” or “Division” shall be deemed to refer to the Medical Board of California.
“(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

“(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

“(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.”

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent Leonard Sunil Kurian, M.D. is subject to disciplinary action under section 2234, subdivision (b), in that he was grossly negligent in the care and treatment of a patient. The circumstances are as follows:

9. On or about September 9, 2010, Patient J.V. had an appointment at Respondent’s office. She complained of heavy, irregular, painful menstrual periods of eight to ten days. An ultrasound exam from the prior day showed large multiple uterine fibroids. The largest one was on the posterior right side measuring 5.8 cm. Another posterior fibroid measured 3.6 cm and an anterior lower uterine segment fibroid measured 3 cm. Medical history was noted to include thyroid dysfunction and anemia. Her obstetric history was noted to include: 4 gravida (total past pregnancies); 2 full term pregnancies; 1 spontaneous abortion; 1 ectopic pregnancy, 2 para (pregnancies producing one or more viable offspring), no c-sections and no hysterectomy. She

2 Patients are referred to by initials in this accusation to protect their privacy.
was not pregnant. Prior surgeries were noted to include breast biopsy of the right breast with a
lumpectomy being benign, tubal ligation, tubal reanastomosis and an ectopic pregnancy in the
right tube. Notes indicated that J.V. stated she was tired of the heavy painful periods and would
like to have a myomectomy since she wanted to preserve her fertility. Respondent noted
discussing a robot assisted uterine myomectomy. Respondent’s notes failed to include: a detailed
medical history; surgical methodology that had been used for the tubal ligation or ectopic
pregnancy; description of a physical examination of J.V.’s abdomen including the location of any
scars from J.V.’s previous surgeries; quantitation of J.V.’s uterine size; or description of palpable
fibroids.

10. On or about November 11, 2010, Respondent conducted a preoperative consultation
with J.V. Respondent documented obtaining informed consent from J.V. for a robotically
assisted (laparoscopic) uterine myomectomy to preserve J.V.’s fertility and chromopertubation. J.V. signed consent forms that she understood and accepted the risks of robot assisted uterine
myomectomy and chromopertubation. J.V. was not advised and did not therefore provide
informed consent with regard to the risk of a prolonged surgery due to Respondent’s having only
performed one or two of the same procedures using the same method before and having received
training for the procedure only about six months previously.

11. There is no documentation that J.V. was provided information about alternative
therapies. An open laparotomy would have taken approximately 90 minutes to 2 hours.
Alternative therapies should have included laparotomy, uterine arterial embolization or Lupron
therapy without surgery, bilateral salpingectomies, endometrial ablation and even hysterectomy.
There is also no documentation that Respondent discussed whether J.V. should receive a thorough
fertility evaluation.

12. There is no documentation of a physical exam except the patient’s pulse, weight and
blood pressure. Respondent’s notes again failed to include: a detailed medical history; surgical
methodology that had been used for the tubal ligation or ectopic pregnancy; description of a

3 Chromopertubation involves instilling dye through the fallopian tubes to assess tubal
patency, relevant to assessing J.V.’s fertility.
1 physical examination of J.V.'s abdomen including the location of any scars from J.V.'s previous
2 surgeries; quantitation of J.V.'s uterine size; or description of palpable fibroids. Additionally,
3 Respondent failed to describe a plan to remove the fibroids from the abdomen, rather than using
4 the morcellator to grind up and extract the tissue, a technique that increases risks of injury to
5 bowel or other organs and risks seeding the abdominal cavity with myomatous tissue cells which
6 have been proven to grow where they land.

13. On November 20, 2010, Respondent issued pre-operative orders. They indicated that
the surgical procedure would include robotic assisted uterine myomectomy and
chromopertubation. Respondent’s notes lacked the same documentation that was lacking in
previous appointments referenced above.¹

14. On November 22, 2010, the patient was admitted for the surgery. Respondent
performed a history and physical examination of J.V. at the hospital. Again, Respondent’s notes
lacked the same documentation that was lacking in previous appointments on September 9,
November 11 and November 20, 2010, referenced above. Patient J.V. signed additional consent
forms that she understood and accepted the risks of robot assisted uterine myomectomy and
chromopertubation.

15. The surgery lasted approximately seven hours. Although chromotubation had been
listed as a procedure on all consents, the operative report lacks any reference to it. Additionally,
although the surgery was performed to “preserve fertility,” the operative report does not mention
or report pelvic adhesions, the condition of J.V.’s fallopian tubes, or the integrity of her
endometrial cavity after the myomectomies. The operative report does not document an
instrument count. The operative report does, erroneously, state that the Rumi catheter was
removed prior to beginning the laparoscopy.

16. On or about November 24, 2010, post op day two, J.V. reported her pain level to be

¹ In previous appointments on September 9 and 11, 2010, Respondent’s notes failed to
include: a detailed medical history; surgical methodology that had been used for the tubal ligation
or ectopic pregnancy; description of a physical examination of J.V.’s abdomen including the
location of any scars from J.V.’s previous surgeries; quantitation of J.V.’s uterine size; a
description of palpable fibroids; or any appropriate plan to remove the fibroids from the abdomen.
increasing during the morning. She requested pain medication. A nurse reported she had an
elevated temperature of 100.1°F. Patient J.V. was not evaluated by exam or laboratory studies
and the etiology of her increased pain and temperature elevation were not determined. Tylenol
was administered to J.V. per Respondent who discharged J.V. over the phone. J.V. was not seen
on the day of discharge with appropriate notes.

17. On or about December 14, 2010, J.V. was seen by Respondent for a brief office visit.
She expressed no complaints. She was shown intraoperative photos. No pelvic examination was
performed. J.V.’s age was noted to be 40 years old when in fact she was 36 years old.

18. On or about January 10, 2011, J.V. was seen at Respondent’s office. She presented
with vaginal odor of two weeks duration. A hospitalist covering Respondent’s office performed a
pelvic examination and found a foreign object in J.V.’s vagina. A cervical cup device was
removed. A complete blood count was ordered. Doxycycline, Flagyl (metronidazole) and
clindamycin were given to J.V. and she was advised to return in 24 hours.

19. On or about January 11, 2011, J.V. had a follow up visit, and reported feeling better
but stating that she was very ill the prior night with fever, nausea and vomiting after taking her
second dose of antibiotics. The hospitalist covering Respondent’s office advised her that she
could discontinue clindamycin but emphasized the importance of completing Flagyl and
doxycycline therapy. J.V. was informed that her complete blood count results were normal. She
was advised to return in two days to evaluate symptomology and review cultures. She provided a
urine sample for analysis. Subsequently, J.V. did not return to Respondent’s office.

20. On or about January 13, 2011, J.V.’s urine culture was reported to be positive for
Escherichia coli (E. coli) which was sensitive to tetracycline. There is no documentation as to

5 Doxycycline is an antibiotic that is used in the treatment of several types of infections
caused by bacteria and protozoa.

6 Metronidazole is also an antibiotic and antiprotozoal medication. It is marketed under
the brand name Flagyl among others.

7 Clindamycin is an antibiotic used to treat certain serious bacterial infections. It is
marketed under the brand name Cleocin.
whether there was follow-up regarding the positive results. Notes show that Bactrim, a product that contains sulfamethoxazole and trimethoprim, antibiotics that treat different types of infection caused by bacteria, was prescribed although the patient was on doxycycline, but there is no documentation of whether J.V. was even informed of the results or provided the prescription or medication.

21. Respondent was grossly negligent in his care and treatment of Patient J.V., taken individually or collectively, when he failed to obtain her informed consent prior to performing surgery on her as follows:

(a) Respondent failed to adequately educate Patient J.V. or document educating her that due to his inexperience and the high learning curve of laparoscopic surgery, there was a risk that the surgery would be prolonged.

(b) Respondent failed to advise Patient J.V. of the risk to her intra-abdominal organs because of scarring and adhesions from previous surgeries.

(c) Respondent failed to advise Patient J.V. about numerous possible alternative surgical and nonsurgical therapies available so that she could fully assess risk and weigh her options.

22. Respondent was grossly negligent in his care and treatment of Patient J.V., taken singularly or collectively, when he repeatedly failed to document necessary information in Patient J.V.’s medical records, as follows:

(a) Respondent failed, in office notes, to include a detailed medical history or evidence of a physical exam.

(b) Respondent failed, in office notes, to document the surgical methodology that had been used for treating J.V.’s prior ectopic or tubal reversal.

(c) Respondent failed, in documenting the physical examination of J.V.’s abdomen, to describe the location of the scars from J.V.’s previous surgeries.

(d) Respondent failed, in office notes, to describe palpable fibroids or quantitate uterine size.

(e) Respondent failed, in the informed consent, to fully explain the robotic
procedure beyond simply stating that the robot facilitates minimally invasive surgery.

(f) Respondent failed, in pre-operative notes and the operative report, to document an appropriate plan to remove the fibroids from J.V.’s abdomen.

(g) Respondent failed, in the operative report or any post-operative notes, to mention chromopertubation or to document its results although it was listed as a procedure on all consents.

(h) Respondent failed, in the operative report, to document pelvic adhesions, the condition of the fallopian tubes or the integrity of the endometrial cavity after the myomectomy although the procedure was performed to preserve J.V.’s fertility.

(i) Respondent failed, in the operative report, to document an instrument count.

(j) Respondent erroneously documented in the operative report that the Rumi catheter was removed prior to beginning the laparoscopy.

(k) Respondent failed, in the operative report, to document the removal of instrumentation from the vagina.

(l) Respondent failed, post-operatively on the day of discharge, to see J.V. and prepare appropriate notes regarding her status.

(m) Respondent failed, in office notes after J.V.’s surgery, to document notifying J.V. of any results of lab work performed in his office or appropriately following up on positive results.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

23. Respondent Leonard Sunil Kurian, M.D. is subject to disciplinary action under section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of a patient. The circumstances are as follows:

24. The facts and circumstances as alleged in paragraphs 9 through 20 are incorporated here as if fully set forth.

25. Respondent was negligent in his care and treatment of Patient J.V., taken individually or collectively, when he failed to obtain her informed consent prior to performing surgery on her
(a) Respondent failed to adequately educate Patient J.V. or document educating her that due to his inexperience and the high learning curve of laparoscopic surgery, there was a risk that the surgery would be prolonged.

(b) Respondent failed to advise Patient J.V. of the risk to her intra-abdominal organs because of scarring and adhesions from previous surgeries.

(c) Respondent failed to advise Patient J.V. about numerous possible alternative surgical and nonsurgical therapies available so that she could fully assess risk and weigh her options.

26. Respondent was negligent in his care and treatment of Patient J.V., taken singularly or collectively, when he repeatedly failed to document necessary information in Patient J.V.’s medical records, as follows:

(a) Respondent failed, in office notes, to include a detailed medical history or evidence of a physical exam.

(b) Respondent failed, in office notes, to document the surgical methodology that had been used for treating J.V.’s prior ectopic or tubal reversal.

(c) Respondent failed, in documenting the physical examination of JV’s abdomen, to describe the location of the scars from JV’s previous surgeries.

(d) Respondent failed, in office notes, to describe palpable fibroids or quantitate uterine size.

(e) Respondent failed, in the informed consent, to fully explain the robotic procedure beyond simply stating that the robot facilitates minimally invasive surgery.

(f) Respondent failed, in pre-operative notes and the operative report, to document an appropriate plan to remove the fibroids from J.V.’s abdomen.

(g) Respondent failed, in the operative report or any post-operative notes, to mention chromopertubation or to document its results although it was listed as a procedure on all consents.

(h) Respondent failed, in the operative report, to document pelvic adhesions,
the condition of the fallopian tubes or the integrity of the endometrial cavity after the
myomectomy although the procedure was performed to preserve J.V.'s fertility.

(i) Respondent failed, in the operative report, to document an instrument count.

(j) Respondent erroneously documented in the operative report that the Rumi
catheter was removed prior to beginning the laparoscopy.

(k) Respondent failed, in the operative report, to document the removal of
instrumentation from the vagina.

(l) Respondent failed, post-operatively on the day of discharge, to see J.V. and
prepare appropriate notes regarding her status.

(m) Respondent failed, in office notes after J.V.'s surgery, to document
notifying J.V. of any results of lab work performed in his office or appropriately following
up on positive results.

27. Postoperatively, Respondent left a foreign object inside of the patient, specifically, a
Rumi catheter cup in the patient’s vagina.

28. Respondent prematurely discharged the patient from the hospital, failing to evaluate
her and evaluate the etiology and for possible infection given that she experienced pain and a
fever over 100 degrees.

THIRD CAUSE FOR DISCIPLINE
(Failure to Maintain Accurate and Adequate Medical Records)

29. Respondent Leonard Sunil Kurian, M.D. is subject to disciplinary action under
section 2266 in that he failed to maintain adequate and accurate records relating to the provision
of services to Patient J.V., thereby committing unprofessional conduct. The circumstances are as
follows:

30. Paragraphs 9 through 20 are incorporated herein as if fully set forth.

DISCIPLINARY CONSIDERATIONS

31. To determine the degree of discipline, if any, to be imposed on Respondent,
Complainant alleges that on or about March 2, 2006, in a prior disciplinary action entitled In the
Matter of the Accusation Against Leonard Sunil Kurian, M.D. before the Medical Board of
California, in Case Number 05-2003-145058, Respondent was issued a Public Reprimand and was required to successfully complete a clinical training program, record keeping course and ethics course based on allegations of unprofessional conduct in the care and treatment of a patient. That decision is now final and is incorporated by reference as if fully set forth herein.

32. To further determine the degree of discipline, if any, to be imposed on Respondent Leonard Sunil Kurian, M.D., Complainant alleges that on or about May 8, 2015, in a prior disciplinary action entitled In the Matter of the First Amended Accusation Against Leonard Sunil Kurian, M.D. before the Medical Board of California, in Case Number 05-2011-214708, Respondent’s license was revoked, the revocation was stayed, and he was placed on probation for seven years and was required, again, to successfully complete a clinical training program, record keeping course and ethics course. Additionally, after successfully completing a clinical training program, Respondent’s probation requires that he participate in a Professional Enhancement Program including quarterly review of Respondent’s charts; semi-annual assessment of Respondent’s practice; and semi-annual review of Respondent’s professional growth and education. The discipline was based on allegations of unprofessional conduct relating to his care and treatment of a patient in 2007 who died, a patient in 2010 and a patient in 2011 who died. That decision is now final and is incorporated by reference as if fully set forth herein.

**PRAYER**

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

1. Revoking or suspending Physician’s and Surgeon’s Certificate Number G 70489, issued to Leonard Sunil Kurian, M.D.;

2. Revoking, suspending or denying approval of Leonard Sunil Kurian, M.D.’s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Leonard Sunil Kurian, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: April 13, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
State of California
Complainant

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