SETTLEMENT AGREEMENT PRIOR TO FILING OF PETITION FOR DISCIPLINARY ACTION AND BOARD'S FINAL ORDER

Petitioner, DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS' REGULATED INDUSTRIES COMPLAINTS OFFICE (hereinafter "RICO" or "Petitioner"), through its undersigned attorney, and Respondent ALLEN T. CANTER, dba ALLEN T. CANTER CONTRACTING, (hereinafter "Respondent"), enter into this Settlement Agreement on the terms and conditions set forth below.

A. UNCONTESTED FACTS

1. At all relevant times herein, Respondent was licensed by the Contractors License Board (hereinafter the "Board") as a specialty contractor under license number CT 13096. The
license was issued on or about August 5, 1992. The license will expire on or about
September 30, 2010.

2. Respondent's mailing address for purposes of this action is 3375 Koapaka Street,
D-139, Honolulu, Hawaii 96819.

3. RICO alleges that Respondent entered into a contract to install tiling in a
customer’s residence and failed to 1) explain in detail the lien rights of all parties performing
under the contract; 2) explain the homeowner’s right to demand bonding on the project; 3)
explain how the bond would protect the homeowner or the approximate expense of the bond; 4)
provide notice of the contractor’s right to resolve alleged construction defects prior to
commencing any litigation under HRS section 672E-11; and 5) disclose the date work was to
commence and the number of days for completion.

4. The foregoing allegations, if proven at an administrative hearing before the Board,
would constitute violations of the following statutes and/or rules: Hawaii Revised Statutes
(HRS) § 444-25.5(a)(1)(verbal disclosure of lien rights); HRS § 444-25.5(a)(2) (verbal disclosure
of bonding rights); § 444-25.5(b)(1)(written disclosure of lien obligations and bonding rights); §
444-25.5(b)(2)(disclosure of Respondent’s Contractor Repair Act rights); Hawaii Administrative
Rules (“HAR”) § 16-77-79(a)(4)(disclosure of bonding rights); § 16-77-80(a)(3)(disclosure of the
date work is to commence and the number of days for completion); and § 16-77-80(a)(7)(disclosure of lien rights).

5. The Board has jurisdiction over the subject matter herein and over the parties
hereto.
B. REPRESENTATIONS BY RESPONDENT:

1. Respondent is fully aware that Respondent has the right to be represented by an attorney and voluntarily waives that right.

2. Respondent enters into this Settlement Agreement freely, knowingly, voluntarily, and under no coercion or duress.

3. Respondent is aware of the right to have a hearing to adjudicate the issues in the case. Pursuant to HRS § 91-9(d), Respondent freely, knowingly, and voluntarily waives the right to a hearing and agrees to dispose of this case in accordance with the terms and conditions of this Settlement Agreement.

4. Respondent being at all times relevant herein licensed as a specialty contractor by the Board acknowledges that Respondent is subject to penalties including but not limited to, revocation, suspension or limitation of the license and administrative fines, if the foregoing allegations are proven at hearing.

5. Respondent represents that he believes that he completed the tiling contract described in paragraph 3, Section A above in a professional manner and that his workmanship was consistent with the standards of the trade.

6. Respondent represents that he believes that the customer’s complaint to RICO was motivated by a conflict the customer has with the customer’s neighbor who is a friend of Respondent’s.

7. Respondent represents that he was unaware of the requirements of HRS § 444-25.5.

8. Respondent does not admit to violating any law or rule, but acknowledges that RICO has sufficient cause to file a Petition for Disciplinary Action against Respondent's license.
9. Respondent enters into this Settlement Agreement as a compromise of the claims and to conserve on the expenses of proceeding with an administrative hearing on this matter.

10. Respondent agrees that this Settlement Agreement is intended to resolve the issues raised in RICO's investigation in RICO Case No. CLB 2007-9-L.

11. Respondent understands this Settlement Agreement is public record pursuant to Hawaii Revised Statutes chapter 92F.

C. TERMS OF SETTLEMENT:

1. Administrative fine. Respondent agrees to pay a fine in the amount of FIVE HUNDRED AND NO/100 DOLLARS ($500.00). Payment shall be made by cashier's check or money order made payable to "DCCA - Compliance Resolution Fund" and mailed to the Regulated Industries Complaints Office, Attn: John T. Hassler, Esq., 235 S. Beretania Street, 9th Floor, Honolulu, Hawaii 96813. Payment of the fine shall be due at the time this fully executed Settlement Agreement is returned to RICO.

2. Failure to Comply with Settlement Agreement. If Respondent fails to fully and timely comply with the terms of this Settlement Agreement as set forth in paragraph C. [1] above, Respondent's license shall be automatically revoked upon RICO's filing of an affidavit with the Board attesting to such failure. In case of such revocation, Respondent shall turn in all indicia of the license to the Executive Officer of the Board within ten (10) days after receipt of notice of the revocation. In case of such revocation, Respondent understands Respondent cannot apply for a new license until the expiration of at least five (5) years after the effective date of the revocation. Respondent understands that if Respondent desires to become licensed again, Respondent must apply to the Board for a new license pursuant to and subject to HRS §§ 92-17, 436B-21, and all other applicable laws and rules in effect at the time.
3. **Possible further sanction.** The Board, at its discretion, may pursue additional disciplinary action as provided by law to include further fines and other sanctions as the Board may deem appropriate if Respondent violates any provision of the statutes or rules governing the conduct of contractors in the State of Hawaii, or if Respondent fails to abide by the terms of this Settlement Agreement.

4. **Approval of the Board.** Respondent agrees that, except for the representations, agreements and covenants contained in Paragraphs C. [5], C. [6], C. [7] and C. [8] below, this Settlement Agreement shall not be binding on any of the parties unless and until it is approved by the Board.

5. **No Objection if Board Fails to Approve.** If the Board does not approve this Settlement Agreement, does not issue an order pursuant thereto, or does not approve a lesser remedy, but instead an administrative hearing is conducted against Respondent in the Board's usual and customary fashion pursuant to the Administrative Procedure Act, Respondent agrees that neither Respondent nor any attorney that Respondent may retain, will raise as an objection in any administrative proceeding or in any judicial action, to the Board's proceeding against Respondent on the basis that the Board has become disqualified to consider the case because of its review and consideration of this Settlement Agreement.

6. **Any Ambiguities Shall be Constrained to Protect the Consuming Public.** It is agreed that any ambiguity in this Settlement Agreement is to be read in the manner that most completely protects the interests of the consuming public.

7. **No Reliance on Representations by RICO.** Other than the matters specifically stated in this Settlement Agreement, neither RICO nor anyone acting on its behalf has made any representation of fact, opinion or promise to Respondent to induce entry into this Settlement Agreement.
Agreement, and Respondent is not relying upon any statement, representation or opinion or promise made by RICO or any of its agents, employees, representatives or attorneys concerning the nature, extent or duration of exposure to legal liability arising from the subject matter of this Settlement Agreement or concerning any other matter.

8. **Complete Agreement.** This Settlement Agreement is a complete settlement of the rights, responsibilities and liabilities of the parties hereto with respect to the subject matter hereof; contains the entire agreement of the parties; and may only be modified, changed or amended by written instrument duly executed by all parties hereto.

IN WITNESS WHEREOF, the parties have signed this Settlement Agreement on the date(s) set forth below.

DATED: Honolulu, HI, 11/1/10

Allen S. Canter

Allen T. Canter

Respondent

DATED: Honolulu, Hawaii, 11/1/10

John T. Hassler

Attorney for Department of Commerce and Consumer Affairs

This decision has been redacted and reformatted for publication purposes and contains all of the original text of the actual decision.
IN THE MATTER OF THE CONTRACTOR'S LICENSE OF ALLEN T. CANTER, dba ALLEN T. CANTER CONTRACTING; SETTLEMENT AGREEMENT PRIOR TO FILING OF PETITION FOR DISCIPLINARY ACTION AND BOARD'S FINAL ORDER; CASE NO. CLB 2007-9-L

APPROVED AND SO ORDERED:
CONTRACTORS LICENSE BOARD
STATE OF HAWAII

F. M. SCOTTY ANDERSON
Chairperson

NEAL ARITA
Vice Chairperson

NOV 22 2010
DATE

GUY M. AKASAKI

JOHN E. K. DILL

RANDALL B. C. LAU

ALDON K. MOCHIDA

DENNY R. SADOWSKI

GERALD YAMADA

PVL 08/25/09

This decision has been redacted and reformatted for publication purposes and contains all of the original text of the actual decision.
STATE OF Hawai‘i

COUNTY OF Honolulu

On this 15th day of November, 2010, before me personally appeared

Allen T. Cantee, to me known to be the person described and who executed the
foregoing instrument and acknowledged the same as his/her free act and deed.

Name: Edna M. Kelley
Notary Public – State of Hawai‘i
My Commission expires: Mar 19, 2018

This decision has been redacted and reformatted for publication purposes and contains all of the original text of the actual decision.
In the Matter of the License to Practice Medicine of AJIT S. ARORA, M.D., Respondent.

SETTLEMENT AGREEMENT PRIOR TO FILING OF PETITION FOR DISCIPLINARY ACTION AND BOARD'S FINAL ORDER

Petitioner, DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS' REGULATED INDUSTRIES COMPLAINTS OFFICE (hereinafter "RICO" or "Petitioner"), through its undersigned attorney, and Respondent AJIT S. ARORA, M.D. (hereinafter "Respondent"), enter into this Settlement Agreement on the terms and conditions set forth below.

A. UNCONTESTED FACTS

1. At all relevant times herein, Respondent was licensed by the Hawaii Medical Board (hereinafter the "Board") as a physician under license number MD 8852. The license was issued on or about July 28, 1994. The license will expire on or about January 31, 2012.
2. Respondent’s mailing address for purposes of this action is 8660 Woodley Avenue, No. 103, North Hills, California 91343.

3. RICO received information a Decision was issued against Respondent by the State of California.

4. RICO alleges a Decision was issued in In the Matter of the First Amended Accusation Against Ajit Singh Arora, M.D. (File No. 06-2006-177822) by the Medical Board of California. RICO alleges that Respondent failed to report the California disciplinary action to the Hawaii Medical Board within thirty days of its issuance as required by law. A copy of the Decision and Order in In the Matter of the First Amended Accusation Against Ajit Singh Arora, M.D. (File No. 06-2006-177822) (“California Order”) is attached as Exhibit “1.”

5. The foregoing allegations, if proven at an administrative hearing before the Board, would constitute violations of the following statute(s) and/or rule(s): Hawaii Revised Statutes (“HRS”) § 453-8(a)(11) (disciplinary action by another state) and § 453-8(a)(14) (failure to report within thirty days).

6. The Board has jurisdiction over the subject matter herein and over the parties hereto.

B. REPRESENTATIONS BY RESPONDENT

1. Respondent is represented by Jay T. Suemori, Esquire, herein.

2. Respondent enters into this Settlement Agreement freely, knowingly, voluntarily, and under no coercion or duress.

3. Respondent is aware of the right to have a hearing to adjudicate the issues in the case. Pursuant to HRS § 91-9(d), Respondent freely, knowingly, and voluntarily waives the right.
to a hearing and agrees to dispose of this case in accordance with the terms and conditions of this Settlement Agreement.

4. Respondent being at all times relevant herein licensed as a physician by the Board acknowledges that Respondent is subject to penalties including but not limited to, revocation, suspension or limitation of the license and administrative fines, if the foregoing allegations are proven at hearing.

5. Respondent does not admit to violating any law or rule, but acknowledges that RICO has sufficient cause to file a Petition for Disciplinary Action against Respondent's license.

6. Respondent enters into this Settlement Agreement as a compromise of the claims and to conserve on the expenses of proceeding with an administrative hearing on this matter.

7. Respondent agrees that this Settlement Agreement is intended to resolve the issues raised in RICO's investigation in RICO Case No. MED 2009-65-L.

8. Respondent understands this Settlement Agreement is public record pursuant to Hawaii Revised Statutes 92F.

C. TERMS OF SETTLEMENT

1. Probation. Respondent’s license to practice medicine in the State of Hawaii is hereby placed on probation for a period to run concurrent with the probationary period set forth in the California Order. During the probationary period, Respondent agrees to comply with the following terms and conditions:

2. Compliance with California Order. Respondent shall:

   (a) fully comply with the terms of probation as set forth in the California Order; and
deliver to the Board a copy of any and all quarterly declarations submitted to the California Medical Board pursuant to the California Order. All such declarations shall be submitted to the Board within the time frame proscribed in the California Order.

3. **Administrative Fine.** Respondent agrees to pay an administrative fine in the amount of THREE THOUSAND AND NO/100 DOLLARS ($3,000.00) as follows:

1) $300.00 within thirty (30) days of the approval of this agreement by the Board;
2) $300.00 within sixty (60) days of the approval of this agreement by the Board;
3) $300.00 within ninety (90) days of the approval of this agreement by the Board;
4) $300.00 within one hundred twenty (120) days of the approval of this agreement by the Board;
5) $300.00 within one hundred fifty (150) days of the approval of this agreement by the Board;
6) $300.00 within one hundred eighty (180) days of the approval of this agreement by the Board;
7) $300.00 within two hundred ten (210) days of the approval of this agreement by the Board;
8) $300.00 within two hundred forty (240) days of the approval of this agreement by the Board;
9) $300.00 within two hundred seventy (270) days of the approval of this agreement by the Board; and
10) $300.00 within three hundred (300) days of the approval of this agreement by the Board.

Payments shall be made by **cashier's check or money order made payable to "DCCA Compliance Resolution Fund"** and shall be mailed to the Regulated Industries Complaints
Office, ATTN: Denise P. Balanay, Esq., 235 South Beretania Street, 9th Floor, Honolulu, Hawaii 96813.

4. **Failure to Comply with Settlement Agreement.** If Respondent fails to fully and timely comply with the terms of this Settlement Agreement as set forth in paragraph(s) C.1 through C.3 above, Respondent's license shall be automatically revoked upon RICO's filing of an affidavit with the Board attesting to such failure. In case of such revocation, Respondent shall turn in all indicia of the license to the Executive Officer of the Board within ten (10) days after receipt of notice of the revocation. In case of such revocation, Respondent understands Respondent cannot apply for a new license until the expiration of at least five (5) years after the effective date of the revocation. Respondent understands that if Respondent desires to become licensed again, Respondent must apply to the Board for a new license pursuant to and subject to HRS §§ 92-17, 436B-21, and all other applicable laws and rules in effect at the time.

5. **Possible further sanction.** The Board, at its discretion, may pursue additional disciplinary action as provided by law to include further fines and other sanctions as the Board may deem appropriate if Respondent violates any provision of the statutes or rules governing the conduct of physicians in the State of Hawaii, or if Respondent fails to abide by the terms of this Settlement Agreement.

6. **Approval of the Board.** Respondent agrees that, except for the representations, agreements and covenants contained in Paragraphs C.7, C.8, C.9, and C.10 below, this Settlement Agreement shall not be binding on any of the parties unless and until it is approved by the Board.
7. **No Objection if Board Fails to Approve.** If the Board does not approve this Settlement Agreement, does not issue an order pursuant thereto, or does not approve a lesser remedy, but instead an administrative hearing is conducted against Respondent in the Board's usual and customary fashion pursuant to the Administrative Procedure Act, Respondent agrees that neither Respondent nor any attorney that Respondent may retain, will raise as an objection in any administrative proceeding or in any judicial action, to the Board's proceeding against Respondent on the basis that the Board has become disqualified to consider the case because of its review and consideration of this Settlement Agreement.

8. **Any Ambiguities Shall be Construed to Protect the Consuming Public.** It is agreed that any ambiguity in this Settlement Agreement is to be read in the manner that most completely protects the interests of the consuming public.

9. **No Reliance on Representations by RICO.** Other than the matters specifically stated in this Settlement Agreement, neither RICO nor anyone acting on its behalf has made any representation of fact, opinion or promise to Respondent to induce entry into this Settlement Agreement, and Respondent is not relying upon any statement, representation or opinion or promise made by RICO or any of its agents, employees, representatives or attorneys concerning the nature, extent or duration of exposure to legal liability arising from the subject matter of this Settlement Agreement or concerning any other matter.

10. **Complete Agreement.** This Settlement Agreement is a complete settlement of the rights, responsibilities and liabilities of the parties hereto with respect to the subject matter hereof; contains the entire agreement of the parties; and may only be modified, changed or amended by written instrument duly executed by all parties hereto.
IN WITNESS WHEREOF, the parties have signed this Settlement Agreement on the
date(s) set forth below.

DATED:  

(Area)  

(City)  

(State)  

(Date)  

AJIT S. ARORA, M.D.  

Respondent  

APPROVED AS TO FORM:  

JAY T. SUEMORI  

Attorney for Respondent  

DATED: Honolulu, Hawaii,  

OCT 13 2010  

DARIA A. LOY-GOTO  
DENISE P. BALANAY  

Attorneys for Department of Commerce and  
Consumer Affairs  

This decision has been redacted and reformatted for publication purposes and contains all of the original text of the actual decision.
IN THE MATTER OF THE LICENSE TO PRACTICE MEDICINE OF AJIT S. ARORA, M.D.; SETTLEMENT AGREEMENT PRIOR TO FILING OF PETITION FOR DISCIPLINARY ACTION AND BOARD’S FINAL ORDER; CASE NO. MED 2009-65-L; EXHIBIT “I”

APPROVED AND SO ORDERED:
HAWAII MEDICAL BOARD
STATE OF HAWAII

DANNY M. TAKANISHI, JR., M.D.
Chairperson

MARIA BRUSCA PATTEN, D.O. -
Vice Chairperson

BRIAN E. CODY

RONALD H. KIENITZ, D.O.

PETER A. MATSUURA, M.D.

G. MARKUS POLIVKA

November 18, 2010
DATE

CARL K. YORITA, M.D.

NIRAJ S. DESAI, M.D.

THOMAS S. KOSASA, M.D.

JOHN T. MCDONNELL, M.D.

PVL 7/01/10

This decision has been redacted and reformatted for publication purposes and contains all of the original text of the actual decision.
STATE OF California }  SS.
COUNTY OF Los Angeles } 

On this 20th day of September, 2016, before me personally appeared

Ajit S. Arora

to me known to be the person described and who

executed the foregoing instrument and acknowledged the same as his free act and deed.

JULIA M. VALENÇIA
Commission # 1754245
Notary Public - California
Los Angeles County
My Comm. Expires: July 26, 2011

Name: JULIA M. VALENÇIA
Notary Public - State of California

My Commission expires: 7/26/11
State of California

County of Los Angeles

On 9/20/10 before me, Julia M. Valencia, Notary Public, personally appeared Ajit S. Arora, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

JULIA M. VALENCIA
Commission # 1784245
Notary Public - California
Los Angeles County
My Comm. Expires July 24, 2011

Description of Attached Document

Title or Type of Document: ______________________________________________________

Document Date: ____________________________ Number of Pages: ____________________

Signer(s) Other Than Named Above: ______________________________________________

Capacity(ies) Claimed by Signer(s)

Signer’s Name: □ Corporate Officer — Title(s): □ Individual
□ Partner — □ Limited □ General
□ Attorney in Fact
□ Trustee
□ Guardian or Conservator
□ Other: ____________________________

Signer Is Representing: ____________________________

Signature of Notary Public: ____________________________

Place Notary Seal and/or Stamp Above

Optional

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

© 2008 National Notary Association • 8350 De Soto Ave., P.O. Box 2402 • Chatsworth, CA 91311-2402 • www.NationalNotary.org Item #5957 Recorder: Call Toll-Free 1-800-876-9827

This decision has been redacted and reformatted for publication purposes and contains all of the original text of the actual decision.
BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation
Against:

AJIT SINGH ARORA, M.D.

Physician's and Surgeon's
Certificate No. G 47654

Respondent

File No. 06-2006-177822
OAH No. L-2008060522

DECISION

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

This Decision shall become effective at 5:00 p.m. on May 7, 2009.

IT IS SO ORDERED April 7, 2009.

MEDICAL BOARD OF CALIFORNIA

By: Shelton Duruisseau, Chair
    Panel A

EXHIBIT "1"
BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation:

AJIT SINGH ARORA, M.D.
33275 Canyon Quail Trail
Agua Dulce, California 91390-4681

Physician’s & Surgeon’s Certificate Number
G47654,

Respondent.

Case No. 06-2006-177822
OAH No. L-2008060522

STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER

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

PARTIES

1. Barbara Johnston (Complainant) is the Executive Director of the Medical
Board of California. She brought this action solely in her official capacity and is represented in
this matter by Edmund G. Brown Jr., Attorney General of the State of California, by Abraham M.
Levy, Deputy Attorney General.

2. Respondent Ajit Singh Arora, M.D. (Respondent) is represented by
attorney Peter R. Osinoff, whose address is 3699 Wilshire Boulevard, 10th Floor, Los Angeles,
CA 90010-2719.

3. On or about June 28, 1982, the Medical Board of California issued
Physician’s and Surgeon’s Number G47654 to Respondent.

JURISDICTION

4. First Amended Accusation was filed before the Medical Board of California (Board) on February 24, 2009, Department of Consumer Affairs, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on February 24, 2009. Respondent had timely filed his Notice of Defense. A copy of the First Amended Accusation is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in the First Amended Accusation No. 06-2006-177822. Respondent has also carefully read, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

8. Respondent understands and agrees that the charges and allegations in the First Amended Accusation, if proven at a hearing, constitute cause for imposing discipline upon his Physician’s and Surgeon’s Certificate Number G47654.

9. For the purpose of resolving the First Amended Accusation, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the First Amended Accusation, and that Respondent hereby gives up his right to contest those charges.
10. Respondent agrees that his Physician’s and Surgeon’s Certificate Number G47654 is subject to discipline and he agrees to be bound by the Medical Board of California (Board)’s imposition of discipline as set forth in the Disciplinary Order below.

RESERVATION

11. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

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

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician’s and Surgeon’s Number G47654 issued to Respondent Ajit Singh Arora M.D. (Respondent) is revoked. However, the revocation
is stayed and Respondent is placed on probation for thirty-five (35) months on the following terms and conditions.

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

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

2. **SUPERVISION OF PHYSICIAN ASSISTANTS** During probation, respondent is prohibited from supervising physician assistants.

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

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

5. **PROBATION UNIT COMPLIANCE** Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

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

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

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

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

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

7. **SOLO PRACTICE** Respondent is prohibited from engaging in the solo
practice of medicine.

8. **CERTIFICATION OF N-648 CLAIMS** Respondent is prohibited from
certifying "Medical Certification for Disability Exception" (N-648) claims for United States
citizenship to any agency of the federal government for purposes of immigration, naturalization
or residency throughout the term of probation.

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

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

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

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

11. FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT

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

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

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

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

13. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

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

15. **PROBATION MONITORING COSTS** Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which are currently set at $3173.00, but may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

**ACCEPTANCE**

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

DATED: 2/25/09.

AJIT SINGH ARORA, M.D. (Respondent)

I have read and fully discussed with Respondent Ajit Singh Arora the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 2/27/09.

PETER R. OSINOFF

Attorney for Respondent
ENDORSEMENT

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

DATED: 3-4-03

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

ABRAHAM M. LEVY
Deputy Attorney General
Attorneys for Complainant

DOJ Matter ID: LA2008501883 50393953.wpd

This decision has been redacted and reformatted for publication purposes and contains all of the original text of the actual decision.
Exhibit A

FIRST AMENDED ACCUSATION CASE NO. 06-2006-177822

This decision has been redacted and reformatted for publication purposes and contains all of the original text of the actual decision.
EDMUND G. BROWN JR., Attorney General of the State of California
ABRAHAM M. LEVY, State Bar No. 189671
Deputy Attorney General
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 897-0977
Facsimile: (213) 897-9395
Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against:
AJIT SINGH ARORA, M.D.
33275 Canyon Quail Trail
Agua Dulce, California 91390-4681
Physician’s & Surgeon’s Certificate Number G47654,
Respondent.

Complainant alleges:

PARTIES
1. Barbara Johnston (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California (the Board).
2. On or about June 28, 1982, the Medical Board of California issued Physician’s and Surgeon’s Number G47654 to Ajit Singh Arora, M.D. (Respondent). This license was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2010, unless renewed.

JURISDICTION
3. This First Amended Accusation supercedes and supplants the original Accusation filed in this matter on December 6, 2007. All section references are to
the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code states:

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

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

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

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

"(4) Be publicly reprimanded by the division.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the division or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the division and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this chapter, the board shall, in addition to any other authority granted by law, have power to:

1. As used herein, the term "Board" means the Medical Board of California. As used herein, "Division of Medical Quality" shall also be deemed to refer to the Board.
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
[Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

**CAUSE FOR DISCIPLINE**

(REPEATED NEGLIGENCE ACTS)

6. Respondent is subject to disciplinary action under Business and
Professions Code section 2234, subdivision (c), for repeated negligent acts in his
evaluation of learning disability with regard to five applicants for United States
citizenship, P.E., C.G., R.V., M.D. and Y.S., each of whom was evaluated by
Respondent in the manner hereafter described at a medical clinic known as the Parthenia
Medical Group, Inc. 8660 Woodley Avenue, North Hills, California 91343-5745.

7. For each of the five applicants previously referenced, Respondent
completed under penalty of perjury a Department of Homeland Security "Medical
Certification for Disability Exception" (Form N-648). In all of the forms, he described
his specialty as "internal medicine, geriatrics, medical toxicology" and used the titles
"M.D." and "Ph.D."

8. Applicants for United States citizenship (also known as
naturalization) are required to learn and/or demonstrate knowledge of the English
language, including an ability to read, write and speak words in ordinary usage in the
English language, as well as knowledge and understanding of the fundamentals of the
history, and of the principles and form of the government of the United States. The
purpose of Form N-648 is to help determine whether the patient is eligible for an
exception (i.e., waiver) of the above requirement for application for United States
citizenship. Individuals who are unable, because of a disability (e.g., a physical or mental
impairment, or combination of impairments), to learn and/or demonstrate this required
knowledge may apply for a "Medical Certification for Disability Exception" which is to be
completed by the applicant's doctor. The impairment(s) must result from anatomical,
physiological, or psychological abnormalities, which can be shown by medically
acceptable clinical and laboratory diagnostic techniques.

2. The full names of the patients is not set forth in the interest of privacy but will be disclosed to the
Respondent upon an appropriate request for discovery.

3. Form N-648 is used by Homeland Security's U.S. Citizenship and Immigration Services. The laws
governing naturalization of immigrants require that applicants for naturalization demonstrate an ability to read,
write and speak the English language and knowledge and understanding of the fundamentals of the history, and of
the principles and form of government, of the United States. A Form 648, signed by a medical professional, is
used to seek a waiver of the English and/or civics requirements based on a physical or developmental disability or
mental impairment.

4. Section 312.2 of title 8 of the Code of Federal Regulations sets forth this requirement as follows:
(a) General. No person shall be naturalized as a citizen of the United States upon his or her own application unless

This decision has been redacted and reformatted for publication purposes and contains all of the original text of the actual decision.
9. Respondent made findings and declared under penalty of perjury that each of the applicants referenced in this Accusation all had impairment(s) that affected their ability to learn and/or demonstrate knowledge and that he based these

that person can demonstrate a knowledge and understanding of the fundamentals of the history, and of the principles and form of government, of the United States. A person who is exempt from the literacy requirement under § 312.1(b) (1) and (2) must still satisfy this requirement.

(b) Exceptions. (1) The requirements of paragraph(a) of this section shall not apply to any person who is unable to demonstrate a knowledge and understanding of the fundamentals of the history, and of the principles and form of government of the United States because of a medically determinable physical or mental impairment, that already has or is expected to last at least 12 months. The loss of any cognitive skills based on the direct effects of the illegal use of drugs will not be considered in determining whether an individual may be exempted. For the purposes of this paragraph the term medically determinable means an impairment that results from anatomical,

physiological, or psychological abnormalities which can be shown by medically acceptable clinical or laboratory diagnosis techniques to have resulted in functioning so impaired as to render any individual to be unable to demonstrate the knowledge required by this section or that renders the individuals unable to participate in the testing procedures for naturalization, even with reasonable modifications.

(2) Medical certification. All persons applying for naturalization and seeking an exception from the requirements of § 312.1(a) and paragraph (a) of this section based on the disability exceptions must submit Form N-648, Medical Certification for Disability Exceptions, to be completed by a medical or osteopathic doctor licensed to practice medicine in the United States or a clinical psychologist licensed to practice psychology in the United States (including the United States territories of Guam, Puerto Rico, and the Virgin Islands). Form N-648 must be submitted as an attachment to the applicant's Form N-400, Application for Naturalization. These medical professionals shall be experienced in diagnosing those with physical or mental medically determinable impairments and shall be able to attest to the origin, nature, and extent of the medical condition as it relates to the disability exceptions noted under § 312.1(b)(3) and paragraph (b)(1) of this section. In addition, the medical professionals making the disability determination must sign a statement on the Form N-648 that they have answered all the questions in a complete and truthful manner, that they (and the applicant) agree to the release of all medical records relating to the applicant that may be requested by the Service and that they attest that any knowingly false or misleading statements may subject the medical professional to the penalties for perjury pursuant to title 18, United Stated Code, Section 1546 and to civil penalties under section 274C of the Act. The Service also reserves the right to refer the applicant to another authorized medical source for a supplemental disability determination. This option shall be invoked when the Service has credible doubts about the veracity of a medical certification that has been presented by the applicant. An affidavit or attestation by the applicant, his or her relatives, or guardian on his or her medical condition is not a sufficient medical attestation for purposes of satisfying this requirement.

(c) History and government examination -- (1) Procedure. The examination of an applicant's knowledge of the history and form of government of the United States shall be given orally by a designated examiner in the English language unless: (i) The applicant is exempt from the English literacy requirement under § 312.1(b), in which case the examination may be conducted in the applicant's native language with the assistance of an interpreter selected in accordance with § 312.4 of this part, but only if the applicant's command of spoken English is insufficient to conduct a valid examination in English; (ii) The applicant is required to satisfy and has satisfied the English literacy requirement under § 312.1(a), but the officer conducting the examination determines that an inaccurate or incomplete record of the examination would result if the examination on technical or complex issues were conducted in English. In such a case the examination may be conducted in the applicant's native language, with the assistance of an interpreter selected in accordance with § 312.4;

(iii) The applicant has met the requirements of § 312.3.

(2) Scope and substance. The scope of the examination shall be limited to subject matters covered in the Service authorized Federal Textbooks on Citizenship except for the identity of current officeholders. In choosing the subject matters, in phrasing questions and in evaluating responses, due consideration shall be given to the applicant's education, background, age, length of residence in the United States, opportunities available and efforts made to acquire the requisite knowledge, and any other elements or factors relevant to an appraisal of the adequacy of the applicant's knowledge and understanding.
findings on an examination of the applicant, the applicant’s symptoms, previous medical records, clinical findings or tests. Respondent also made findings and declared under penalty of perjury that in his professional opinion the impairments had lasted or that he expected them to last 12 months or longer. Finally, Respondent declared that all of the applicants’ impairments were not the direct effect of the illegal use of drugs. His examination of the applicant lasted about twenty minutes, and he made these findings without reviewing any medical records, or collecting or ordering any collateral information, such as laboratory or other diagnostic tests, although other employees in his office took a history and performed a screening mental status evaluation. Each applicant paid Respondent $150.00.

10. Upon Respondent’s completion of the forms on behalf of the five applicants, he placed each form in a sealed envelope and directed the applicants to submit them to the United States Citizenship and Immigration Services (USCIS), formerly known as the Immigration and Naturalization Service (INS), without opening the envelope. The envelope, provided by Respondent states as follows: “DO NOT OPEN RETURN TO INS WITH YOUR APPLICATION.” A copy of the N-648 forms submitted to the USCIS are found in each of the applicants’ medical records.

APPLICANT P.E.

11. P.E. (a 58-year-old male) was seen by Respondent on or around March 26, 2002 and August 5, 2003.

12. On March 26, 2002, a female at Respondent’s office took his pulse, blood pressure, height, and weight. Dr. Arora, who only spoke a few words of Spanish, used a stethoscope to check his chest and back and asked him about his health problems. Respondent did not perform any other examination or test of the patient. Respondent did not ask to review any of the patient’s previous medical records. The patient was never asked if he had engaged in the illegal use of drugs. The patient’s medical record contains
The applicant's medical record contains a copy of a Form N-648 signed and dated March 26, 2002 by both the applicant and Respondent. That form describes that Respondent diagnosed the applicant with “1. post-concussive syndrome DSM IV 310.2 and severe persistent headaches with watery eyes.” He also diagnosed him with a “moderately-severe cognitive impairment” explaining that this was supported by his score of 12/30 on a standardized MMSE. He concluded that “in his professional opinion, [the applicant’s] mental disability makes it impossible for him to learn the English language, American history or civics. There is no finding of depression.

14. On or about August 5, 2003, Respondent signed and submitted another Form N-648 containing a reference to the March 26, 2002 visit to Respondent’s office stating “no improvement, not treated here.” The form, which was submitted to immigration authorities, also contains information as follows:

A. Respondent provided a diagnosis of P.E.’s impairments as “1. osteoarthritis bilateral lower extremities, 2. chronic headaches.” In providing the DSM-IV codes for each of the mental impairments he diagnosed, he listed “1. post-concussive syndrome (post-traumatic brain syndrome) DSM IV 310.2, 2. endogenous (sic) depression DSM-IV 296.24.”

B. Respondent also diagnosed P.E. with a “severe mental dysfunction and learning disability,” explaining that this was supported by his score of 10/30 on

5. The mini-mental state examination (MMSE) or Folstein test (Folstein et al 1975) is a 30-point questionnaire test that is used to assess cognition. It is commonly used in medicine to screen for dementia but should not replace a complete clinical assessment of mental status. It samples various functions, including arithmetic, memory and orientation.
a standardized MMSE.

C. Respondent described the connection between the applicant’s impairment and his inability to learn and/or demonstrate knowledge of English and/or U.S. history and civics as the combined result of two head injuries, one at age five and the other at age 55, which resulted in “traumatic cell death and loss of cells necessary for processing information” and “onset of severe post concussive syndrome manifested by cognitive dysfunction as well as chronic headaches.” Respondent adds a reference to the applicant’s depression as another factor that “prevents him from concentrating and processing information.”

D. Respondent concludes that in his professional opinion a “combination of mental and physical factors” has “created a state of learning disability in [the applicant] severe enough to prevent him from learning English, American History and Civics.”

E. Respondent determined that none of the impairments he found were the direct effect of the illegal use of drugs.

15. Respondent was negligent in his evaluation of P. E. as follows:

A. Respondent failed to state in the INS Form 648 that his diagnosis was “probable,” “possible,” or that his diagnostic impression needed to be ruled out by further evaluation or testing. The standard of care for psychiatric evaluation and diagnosis requires a psychiatric evaluation that would routinely last more than an hour and include the taking of a full medical history, conducting a physical examination, obtaining the nature of the patient’s presenting complaints, recording the patient’s family and psycho social history, summarizing the patient’s activities of daily living, conducting a mental status examination, and, as necessary, psychological testing. Respondent deviated from the standard of care by conducting a twenty-minute evaluation, and failing to conduct a full medical history, obtain the nature of the applicant’s presenting complaints, inquire into the applicant’s family and psycho social history, perform a mental status examination,
and order further psychological testing. While Respondent did briefly describe the applicant’s job as a janitor in a cemetery, no attention was given to describe the tasks he was assigned in that role. Accordingly, this very brief collection of information did not meet the standard of care requiring that he obtain a summary of the applicant’s activities of daily living.

B. Respondent deviated from the standard of care by failing to perform definitive psychological testing, which would be necessary to quantify a patient’s purported cognitive defects.

C. The standard of care to reach any psychiatric diagnosis requires a physician to evaluate an individual’s mental capacity by performing a thorough evaluation, which would include laboratory and neuro-diagnostic testing, as necessary. Respondent deviated from the standard of care by diagnosing P.E. with a mental impairment without evaluating the applicant’s mental capacity and by rendering his diagnosis for this applicant without ordering or reviewing any laboratory or neuro-diagnostic testing.

D. The standard of care required that Respondent request and review medical records and/or gather collateral information prior to reaching his diagnosis that P.E. had mental impairments. His failure to do so is a deviation from the standard of practice.

E. Respondent’s failure to consider that the administration of the English-version of the MMSE using a Spanish-interpreter, and the patient’s formal education of only three years between the ages of five and eight, as an explanation for an abnormal result is a deviation from the standard of practice.

APPLICANT C. G.

16. C. G. (a 56-year-old female) was seen by Respondent on or around October 13, 2003 for approximately twenty minutes. Respondent took her blood pressure, checked her heart, and asked her questions about her health. Respondent did not perform any other examination or test of the patient. Respondent did not ask to review any
of the applicant’s previous medical records. The applicant was never asked if she had engaged in the illegal use of drugs. She gave a history of being nervous and forgetting things. There is no documentation of any family mental health history. The medical record only contains a two-page “Internal Medicine Evaluation” signed by Respondent documenting that no physical examination took place. Respondent did not perform an evaluation of the applicant’s psycho-social history, development history or daily activities.

17. On or about October 13, 2003, Respondent signed and submitted a Form N-648 containing the following information.

A. Respondent provided a diagnosis of C.G.’s impairments as “1. chronic headaches severe, 2. insomnia fatigue severe, 3. estrogen deficiency menopause severe.” In providing the DSM-IV codes for the mental impairment he diagnosed, he listed “1. anxiety and panic disorder- severe familial DSM-IV 293.89.”

B. Respondent also diagnosed her with a “significant mental dysfunction” explaining that this was supported by her score of 13/30 on a standardized MMSE and that “this is indicative of moderately severe global mental dysfunction. Her score was 1/8 in areas dealing with attention and recall indicating significant loss of learning ability.”

C. Finally, Respondent described the connection between the applicant’s impairment and her inability to learn and/or demonstrate knowledge of English and/or U.S. history and civics as a “familial form of anxiety and panic disorder which was present in her mother” in addition to “basal motor instability from estrogen deprivation [which] have now put her into a state of chronic anxiety and panic.”

D. Respondent further stated that “her panic attacks are brought on by the slightest confrontation such as interviews, examinations or classroom” and that “when it come to a formal situation the panic state develops with complete loss of ability to relate to the surroundings, mental blank and loss of ability to express
herself.” He concluded that “her anxiety and panic disorder prevents her from classroom learning, attending interviews or examinations.”

E. Respondent determined that none of the impairments he found was the direct effect of the illegal use of drugs.

18. Respondent was negligent in his evaluation of C.G. as follows:

A. The standard of care required that Respondent perform a physical examination to exclude medical causes for his diagnosis of this applicant’s “panic attacks.” His failure to do so is a departure from the standard of care.

B. Respondent failed to state in the INS Form 648 that his diagnosis was “probable,” “possible,” or that his diagnostic impression needed to be ruled out by further evaluation or testing. The standard of care for psychiatric evaluation and diagnosis requires a psychiatric evaluation that would routinely last more than an hour and include the taking of a full medical history, conducting a physical examination, obtaining the nature of the patient’s presenting complaints, recording the patient’s family and psycho social history, summarizing the patient’s activities of daily living, conducting a mental status examination, and, as necessary, psychological testing. Respondent deviated from the standard of care by conducting a twenty-minute evaluation, and failing to conduct a full medical history, obtain the nature of the applicant’s presenting complaints, inquire into the applicant’s family and psycho social history, perform a mental status examination, and ordering further psychological testing.

C. Respondent deviated from the standard of care by failing to perform definitive psychological testing, which would be necessary to quantify the applicant’s purported cognitive defects.

D. The standard of care in reaching a psychiatric diagnosis requires a physician to evaluate an individual’s mental capacity by performing a thorough evaluation, which would include laboratory and neuro-diagnostic testing, as necessary. Respondent deviated from the standard of care by diagnosing C.G. with
a mental impairment without evaluating the applicant’s mental capacity.

Respondent also deviated from the standard of care by diagnosing C.G. with a mental impairment without ordering or reviewing any laboratory or neurodiagnostic testing.

E. The standard of care required that Respondent request and review medical records and/or gather collateral information prior to reaching his diagnosis that C.G. had a mental impairment. Respondent’s failure to do so is a deviation from the standard of practice.

F. Respondent’s failure to consider that the administration of the English-version of the MMSE using a Spanish-interpreter, or information regarding the applicant’s formal education, as an explanation for an abnormal MMSE result is a deviation from the standard of practice.

**APPLICANT M.D.**

19. M.D. (a 66-year-old female) was seen by Respondent on or around December 13, 2004. M.D. denied any history of domestic violence with her husband of fifty years. Her medical record reflects that she took lansoprazole, naproxen (a pain reliever), HCTZ, and benazepril. There is an indication that she denied ever taking illegal drugs. The medical record contains a completed three-page “Evaluation for Citizenship Learning Disability” form. It also contains a two-page “Internal Medicine Evaluation” signed by Respondent documenting that no physical examination took place. Respondent did not perform any examination or test of the applicant. Respondent did not ask to review any of the applicant’s previous medical records. The applicant reported that

6. Lansoprazole is a proton pump inhibitor which prevents the stomach from producing acid.

7. HCTZ (hydrochlorothiazide or HCT) is a prescription medicine that is used to treat high blood pressure and fluid retention. It is part of a class of medicines known as diuretics.

8. Benazepril is used alone or in combination with other medications to treat high blood pressure. Benazepril is in a class of medications called angiotensin-converting enzyme (ACE) inhibitors. It works by decreasing certain chemicals that tighten the blood vessels, so blood flows more smoothly.
she had formal education to the third grade

20. On or about December 13, 2004, Respondent signed and submitted a Form N-648 containing the following information.

A. Respondent provided a diagnosis of M.D.'s impairments as “1. coronary heart disease, 2. hypertension, 3. osteoarthritis, 4. chronic headaches, 5. insomnia fatigue, 6. hypertensive cerebro-vascular disease, 7. osteoporosis bone pain, 8. sleep apnea-hypoapena syndrome.” In providing the DSM-IV codes for each of the mental impairments he diagnosed, he listed “1. vascular dementia DSM IV 290.4, 2. dementia secondary to hypoxic encephalopathy DSM-IV 292.82, 3. endogenous depression DSM-IV 296.24.”

B. He also diagnosed her with a “learning disability” explaining that this was supported by her score of 13/30 on a standardized MMSE and that this indicative of a “significant mental dysfunction” and “compatible with moderately severe global cognitive impairment and learning disability.”

C. He described the connection between the applicant’s impairment and her inability to learn and/or demonstrate knowledge of English and/or U.S. history and civics as “Vascular dementia is the result of hypertensive cerebrovascular disease with vascular damage to brain tissue with focal loss of brain cells through micro-infarctions. That has caused disruption of neurological pathways necessary for processing and reproducing information. That has severely impaired her ability to memorize and reproduce information, and therefore, learning disability. The vascular dementia has been further compromised by hypoxic insult to the brain tissue because of sleep apnea and repeat episodes of hypoxemia during the night. Over the years, this has caused hypoxic insult to the brain cells further augmenting and aggravating vascular dementia and learning disability.” With respect to the diagnosis of depression, Respondent adds that this has been caused by “psychosocial factors, specifically spousal abuse.”

D. Respondent concluded that she had a “severe learning disability that
prevents her from participating in and completing a course of learning in any
subjective matter or language, including the English language, American History
and Civics" and that her “clinical and mental conditions [ . . . ] severely limit [the
applicant’s] ability to successfully participate in any interview and examination,
and express herself. She cannot demonstrate any fund of knowledge that she may
possess about a subject matter or language.”

21. Respondent was negligent in his evaluation of M.D. as follows:

A. Respondent failed to state in the INS Form 648 that his diagnosis
was “probable,” “possible,” or that his diagnostic impression needed to be ruled
out by further evaluation or testing. The standard of practice for diagnosing the
suspected vascular dementia, hypoxic encephalopathy, and cognitive defects that
Respondent found in the applicant requires a neurological examination, the taking
of serum chemistries, conducting neurological imaging, and neuropsychological
testing. Respondent failure to perform a neurological examination, serum
chemistries, neurological imaging, and neuropsychological testing on the applicant
is a deviation from the standard of practice.

B. Respondent failed to perform a complete psychiatric history and
mental status examination of the applicant. Because of this, Respondent failed to
elicit sufficient symptoms to diagnose depression. Further, Respondent’s finding of
a normal physical examination conflicts with his finding of sleep apnea and the
history elicited also fails to reflect sufficient symptoms to support this diagnosis.
Accordingly, Respondent’s failure to perform and document a sufficient history to
elicit sufficient symptoms to support his diagnoses of depression and sleep apnea is
a deviation from the standard of care.

C. The standard of care for psychiatric evaluation and diagnosis
requires a psychiatric evaluation that would routinely last more than an hour and
include the taking of a full medical history, conducting a physical examination,
obtaining the nature of the patient’s presenting complaints, recording the patient’s
family and psychosocial history, summarizing the patient’s activities of daily
living, conducting a mental status examination, and, as necessary, psychological
testing. Respondent deviated from the standard of care by conducting a twenty-
minute evaluation, and failing to conduct a full medical history, obtain the nature
of the applicant’s presenting complaints, inquire into the applicant’s family and
psychosocial history, perform a mental status examination, and order further
psychological testing.

D. Respondent deviated from the standard of care by failing to perform
definitive psychological testing, which would be necessary to quantify the
applicant’s purported cognitive defects.

E. The standard of care in reaching a psychiatric diagnosis requires a
physician to evaluate an individual’s mental capacity by performing a thorough
evaluation, which would include laboratory and neuro-diagnostic testing, as
necessary. Respondent deviated from the standard of care by diagnosing M.D.
with a mental impairment without evaluating the applicant’s mental capacity.
Respondent also deviated from the standard of care by diagnosing M.D. with a
mental impairment without ordering or reviewing any laboratory or
neurodiagnostic testing.

F. The standard of care required that Respondent request and review
medical records and/or gather collateral information prior to reaching his diagnosis
that M.D. had a mental impairment. His failure to do so is a deviation from the
standard of practice.

G. Respondent’s failure to consider that the administration of the
English-version of the MMSE using a Spanish-interpreter, and the applicant’s
formal education to the third grade, as an explanation for an abnormal MMSE
result is a deviation from the standard of practice.

APPLICANT R.V.

22. R.V. (a 62-year-old female) was seen at Respondent’s
office by a female on or around December 27, 2004. A female at Respondent's office
took her blood pressure, checked her heart, and asked her questions about her head. The
entire office visit took 45 minutes. The patient was never asked if she had engaged in the
illegal use of drugs. The medical record contains a completed 3-page “Evaluation for
Citizenship Learning Disability” form. It also contains a one-page “Internal Medicine
Evaluation.”

23. On or about December 27, 2004, Respondent signed and submitted
a Form N-648 containing the following information.

A. Respondent provided a diagnosis of R.V.'s impairments as “1. osteoarthritis, 2. chronic low back pain, 3. chronic headaches, 4. insomnia fatigue, 5. chronic pain.” In providing the DSM-IV codes for each of the mental impairments he diagnosed, he listed “1. endogenous depression 296.24.”

B. Respondent diagnosed her with a “severe learning disability” explaining that this was supported by her score of 16/30 on a standardized MMSE and that this was indicative of “moderate global and mental impairment. She scored 0/8 on retention and recall sections indicating severely impaired ability to perform simple intellectual functions that require short-term memory, concentration and recall.”

C. Respondent described the connection between the applicant’s impairment and her inability to learn and/or demonstrate knowledge of English and/or U.S. history and civics as a “15-year history of endogenous depression, which has remained untreated. The condition is caused by a chemical imbalance in the brain and disruption of proper neurotransmission. The result is dysregulated mental function with impaired perception of the environment and a lack of ability to perceive and respond to stimuli appropriately. The disrupted neurotransmission

9. Endogenous depression is a type of depression caused by somatic or biological factors rather than environmental influences, in contrast to a reactive depression (q.v.). It is usually identified with a specific symptom complex—psychomotor retardation, early morning awakening, weight loss, excessive guilt, and lack of reactivity to the environment—that is roughly equivalent to the symptoms of major depressive disorder.
in [the applicant] has resulted in a loss of ability to concentrate, assimilate, process, register, retain and reproduce information. This translates into a severe learning disability.”

D. Respondent concluded that the applicant had a “severe learning disability that prevents her from attending school and completing a course of learning in any new subject matter or language” and that she lacked “the mental capacity to demonstrate any fund of knowledge that she may possess. She cannot succeed in any formal interview or examinations as required by INS for naturalization purposes.”

E. Respondent determined that none of the impairments he found were the direct effect of the illegal use of drugs.

24. Respondent was negligent in his evaluation of R.V. as follows:

A. Respondent failed to state in the INS Form 648 that his diagnosis was “probable,” “possible,” or that his diagnostic impression needed to be ruled out by further evaluation or testing. Respondent’s diagnosis of “endogenous depression” was based on events that allegedly occurred fifteen years prior to the examination and was not based on a proper mental status examination or on other information to make a clinical diagnosis of depression. Respondent’s methods deviate from the standard of practice for making a clinical diagnosis of depression.

B. Respondent’s conclusion that the applicant had osteoarthritis and chronic pain was not based on any testing, such as serum chemistry results, radiographs or prior medical records containing this data, or based in the medical history taken or on any physical examination. Respondent’s conclusion that the applicant had osteoarthritis and chronic pain is a deviation from the standard of care.

C. The standard of care for psychiatric evaluation and diagnosis requires a psychiatric evaluation that would routinely last more than an hour and
include the taking of a full medical history, conducting a physical examination,

obtaining the nature of the patient’s presenting complaints, recording the patient’s

family and psycho social history, summarizing the patient’s activities of daily

living, conducting a mental status examination, and, as necessary, psychological
testing. Respondent deviated from the standard of care by failing to conduct a full
medical history, obtain the nature of the applicant’s presenting complaints, inquire
into the applicant’s family and psycho social history, perform a mental status
examination, and order further psychological testing. R.V. does not recall that she
ever saw Respondent.

D. Respondent deviated from the standard of care by failing to perform
definitive psychological testing, which would be necessary to quantify the
applicant’s purported cognitive defects.

E. The standard of care in reaching a psychiatric diagnosis requires a
physician to evaluate an individual’s mental capacity by performing a thorough
evaluation, which would include laboratory and neuro-diagnostic testing, as
necessary. Respondent deviated from the standard of care by diagnosing R.V. with
a mental impairment without evaluating the applicant’s mental capacity.
Respondent also deviated from the standard of care by diagnosing R.V. with a
mental impairment without ordering or reviewing any laboratory or neuro-
diagnostic testing.

F. The standard of care required that Respondent request and review
medical records and/or gather collateral information prior to reaching his diagnosis
that R.V. had a mental impairment. His failure to do so is a deviation from the
standard of practice.

G. Respondent’s failure to consider that the administration of the
English-version of the MMSE using a Spanish-interpreter, and the applicant’s
formal education to the sixth grade, as an explanation for an abnormal MMSE
result is a deviation from the standard of practice.
APPLICANT Y.S.

25. Y.S. (a 57-year-old female) was seen by Respondent on or around March 5, 2005. She reported that she has never had heart problems, chronic headaches, insomnia, vascular dementia, or brain damage. She also denied any history of sexual or mental abuse. The medical record contains a completed 5-page “Citizenship Learning Disability Evaluation” questionnaire. It also contains a two-page “Internal Medicine Evaluation” signed by Respondent. Respondent noted in the applicant’s medical records that the applicant had “some knowledge of English” and that the applicant was crying “as she memorized (sic) her stepfather raping her. When asked whether she feels depressed or anxious about the issue again, she says “no.” The applicant was never asked if she had engaged in the illegal use of drugs. Respondent did not ask to review any of the patient’s previous medical records. The applicant reported a formal education to the sixth grade.

26. On March 9, 2005, Respondent signed and submitted a Form N-648 containing the following information.

A. Respondent provided a diagnosis of Y.S.’s impairments as “1. coronary heart disease, 2. hypertension, 3. hypercholesterolemia; 4. chronic headaches, 5. insomnia fatigue, 6. hypertensive cerebro-vascular disease, 7. head injury, brain trauma-concussion.” In providing the DSM-IV codes for each of the mental impairments he diagnosed, he listed “1. post-concussive syndrome DSM-IV 310.2, 2. vascular dementia DSM-IV 290.4, 3. anxiety and panic disorder DSM-IV 293.89.”

B. Respondent diagnosed Y.S. with a learning disability explaining that “When tested by a standardized MMSE, [the applicant] scored 17/30 indicating moderate global cognitive dysfunction as well as learning disability.”

10. Vascular dementia is the second most common form of dementia after Alzheimer disease. The condition is not a single disease; it is a group of syndromes relating to different vascular mechanisms. Patients who have had a stroke are at increased risk for vascular dementia.
C. Respondent described the connection between the Y.S.' impairment and her inability to learn and/or demonstrate knowledge of English and/or U.S. history and civics as follows “Vascular dementia in [the patient] is a result of the vascular damage to the brain tissue with irreversible loss of brain cells. This has disrupted important neurologic pathways necessary for memorizing and committing information to long-term memory. This severely limits her ability to learn any new subject matter or a language. Vascular dementia has been further compounded by element of postconcussive syndrom and caused by head trauma and irreversible damage to brain cells. This has aggravated vascular dementia and learning disability.”

D. Respondent determined that none of the impairments he found were the direct effect of the illegal use of drugs.

27. Respondent was negligent in his evaluation of Y.S. as follows:

A. Respondent failed to state in the INS Form 648 that his diagnosis was “probable,” “possible,” or that his diagnostic impression needed to be ruled out by further evaluation or testing. The standard of practice for diagnosing the suspected vascular dementia, hypoxic encephalopathy, and all of the cognitive defects that Respondent found in applicant Y.S. requires a neurological examination, serum chemistries, neurological imaging, and neuropsychological testing. Respondent failure to perform a neurological examination, serum chemistries, neurological imaging, and neuropsychological testing on patient Y.S. is a deviation from the standard of practice.

B. The standard of care for psychiatric evaluation and diagnosis requires a psychiatric evaluation that would routinely last more than an hour and includes the taking of a full medical history, conducting a physical examination, obtaining the nature of the patient’s presenting complaints, recording the patient’s family and psycho social history, summarizing the patient’s activities of daily living, conducting a mental status examination, and as necessary, psychological
testing. Respondent deviated from the standard of care by conducting a twenty-
minute evaluation, and failing to conduct a full medical history, obtain the nature
of the applicant's presenting complaints, inquire into the applicant's family and
psychosocial history, perform a mental status examination, and order further
psychological testing.

C. Respondent deviated from the standard of care by failing to
perform definitive psychological testing, which would be necessary to
quantify applicant Y.S.' purported cognitive defects.

D. The standard of care in reaching a psychiatric diagnosis
requires a physician to evaluate an individual's mental capacity by
performing a thorough evaluation, which would include laboratory and
neuro-diagnostic testing, as necessary. Respondent deviated from the
standard of care by diagnosing Y.S. with a mental impairment without
evaluating the patient's mental capacity. Respondent also deviated from
the standard of care by diagnosing Y.S. with a mental impairment without
ordering or reviewing any laboratory or neuro-diagnostic testing.

E. The standard of care required that Respondent request and review
medical records and/or gather collateral information prior to reaching his diagnosis
that Y.S. had a mental impairment. His failure to do so is a deviation from the
standard of practice.

F. Respondent's failure to consider that the administration of the
English-version of the MMSE using a Spanish-interpreter, and the applicant's
formal education to the sixth grade, as an explanation for an abnormal result
MMSE is a deviation from the standard of practice.
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 G47654, issued to Ajit Singh Arora, M.D.

2. Revoking, suspending or denying approval of his authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

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


BARTER JOHNSTON
Executive Director
Medical Board of California
State of California
Complainant