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

In the Matter of the Accusation Against: 
FRANK YUN JIA ZHANG, M.D. Case No. 03-2013-233405
Physician's and Surgeon's Certificate No. A 53395
Respondent.

DECISION

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

This Decision shall become effective at 5:00 p.m. on October 1, 2015.

IT IS SO ORDERED September 24, 2015.

MEDICAL BOARD OF CALIFORNIA

By: Kimberly Kirchmeyer, Executive Director
BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Case No. 03-2013-233405
Frank Yun Jia Zhang, M.D. STIPULATED SURRENDER OF
37497 Fremont Blvd. LICENSE AND ORDER
Fremont, CA 94536
Physician’s and Surgeon’s Certificate
Nó. A 53395
Respondent.

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

PARTIES

1. Kimberly Kirchmeyer (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 Kamala D. Harris, Attorney General of the State of California, by Brenda P. Reyes,
Deputy Attorney General.

2. Frank Yun Jia Zhang, M.D. (Respondent) is represented in this proceeding by
attorney David T. Shuey, Esq., whose address is Rankin, Sproat, Mires, Reynolds, Shuey &
Mintz, 1970 Broadway, Suite 1150, Oakland, CA 94612.
3. On or about August 10, 1994, the Medical Board of California issued Physician's and
Surgeon's Certificate No. A 53395 to Respondent. The Physician's and Surgeon's Certificate was
in full force and effect at all times relevant to the charges brought in Accusation No. 03-2013-
233405 and will expire on March 31, 2016, unless renewed.

JURISDICTION

4. Accusation No. 03-2013-233405 was filed before the Medical Board of California
(Board), Department of Consumer Affairs, and is currently pending against Respondent. The
Accusation and all other statutorily required documents were properly served on Respondent on
April 24, 2013. Respondent timely filed his Notice of Defense contesting the Accusation. A
copy of Accusation No. 03-2013-233405 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the
charges and allegations in Accusation No. 03-2013-233405. Respondent also has carefully read,
fully discussed with counsel, and understands the effects of this Stipulated Surrender of License
and 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 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 that the charges and allegations in Accusation No. 03-2013-
233405, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and
Surgeon's Certificate.
9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent hereby gives up his right to contest that cause for discipline exists based on the charges in the Accusation.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. 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 surrender, without notice to or participation by Respondent or his counsel. 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 Surrender 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.

12. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including Portable Document Format (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

13. 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 Order:

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ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 53395, issued to Respondent Frank Yun Jia Zhang, M.D., is surrendered and accepted by the Medical Board of California.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Medical Board of California.

2. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 03-2013-233405 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 03-2013-233405 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, David T. Shuey, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: Sept 14, 2015
FRANK YUN JIA ZHANG, M.D.
Respondent

I have read and fully discussed with Respondent Frank Yun Jia Zhang, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: Sept 17, 2015
DAVID T. SHUEY, ESQ.
Attorney for Respondent

ENDORSEMENT

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

Dated: September 21, 2015
KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

BRENTA P. REYES
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 03-2013-233405
In the Matter of the Accusation Against:

Frank Yun Jia Zhang, M.D.
37497 Fremont Blvd.
Fremont, CA 94536

Physician's and Surgeon's Certificate
No. A 53395,

Respondent.

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, Department of Consumer Affairs.

2. On or about August 10, 1994, the Medical Board issued Physician's and Surgeon's Certificate Number A 53395 to Frank Yun Jia Zhang, 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 March 31, 2016, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states, in relevant part:

"The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board."

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, in relevant part:

"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.

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\(^1\) The term "board" means the Medical Board of California. "Division of Medical Quality" shall also be deemed to refer to the Medical Board. (Bus. & Prof. Code, § 2002.)
"(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."

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."

8. Section 725 of the Code provides that repeated acts of clearly excessive administering of treatment as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon.

FIRST CAUSE FOR DISCIPLINE

(Re: Patient FC)

(Unprofessional Conduct/Gross Negligence/Repeated Negligent Acts/Incompetence/Excessive Treatment)

9. Patient FC,² an 85-year-old woman, was first seen by Respondent in or about January 2007. Respondent is Patient FC’s primary care physician. Respondent’s records for Patient FC do not contain documentation of a complete history and physical examination, nor summary of past medical history. Respondent’s records for Patient FC from 2007 to 2011 document that Patient FC reported ongoing complaints of headaches, lumbar pain, and poor memory. On May

² Patient names are kept confidential to protect their right to privacy but will be identified to Respondent in discovery.
14, 2007, in response to an inquiry by the Department of Human Services, City and County of San Francisco, as to whether FC qualified for in-home supportive services, Respondent reported that FC’s diagnoses included left knee arthritis and depression. Nowhere else in his records does Respondent chart that the patient suffers from depression, nor does he chart any treatment provided for the condition. In response to a similar inquiry in November 2007 by the Social Service Agency of Alameda County, Respondent reported that FC’s diagnoses included arthritis and diabetes. Nowhere else in his records does Respondent chart that the patient suffers from diabetes, nor does he chart any treatment provided for the condition. Respondent’s records document that he diagnosed patient FC with coronary artery disease but there is no charted pertinent past or present history of symptoms, events or treatment. Respondent’s records document that he diagnosed and treated FC for hypertension. Respondent’s records for Patient FC do not document health care maintenance, such as colon screening or mammography for breast cancer screening. Portions of Respondent’s records are illegible.

10. Respondent’s records document that from approximately May 2007 through December 2007, he provided physical therapy treatments to Patient FC for complaints of left knee and low back pain. Respondent’s records document that he again provided physical therapy treatments to Patient FC from June through August 2008 for complaints of cervical, and upper and lower back pain.

11. On January 22, 2011, Patient FC saw Respondent and reported being in a car accident on January 12, 2011, and that she had been taken to an emergency room (ER). FC complained of severe headache, whole body pain, back/lumbar pain, and leg and knee pain. FC also reported that she felt pain when walking, causing her to limp. Respondent documented an examination and diagnosed lumbar sprain/strain, knee sprain/strain, abdominal wall and chest wall injury, and rib/sternum wall fracture. Respondent’s plan included obtaining the ER medical records, physical therapy, and a bone scan or CT scan of the chest wall.

12. Respondent’s records for Patient FC do not indicate that he ever requested nor obtained the medical records of FC’s ER visit. Respondent’s medical records for Patient KC (See Second Cause for Discipline, below) contain copies of billings for FC’s ER treatment. The
billings indicate that FC was taken by ambulance on January 12, 2011 to Highland Hospital in
Oakland, CA. She received CT scans of her head, chest, abdomen, pelvis, and C-spine. FC was
given fentanyl, a narcotic, intravenously during the hospital evaluation.

13. Respondent saw FC on April 26, 2011 and documented that FC continued to
complain of pain and tenderness throughout her body. Respondent documented an examination.
His assessment included consideration of chest wall contusion, "clinical sterna bone fracture,"
and, multiple rib fractures; aggravation of lumbar radiculopathy; cervical, thoracic, and lumbar
and sacral muscle sprain and strain; knee and leg pain; and, "head brain concussion."
Respondent’s plan included no lifting more than five pounds, "oral medication," and physical
therapy (PT). Respondent failed to consider and order imaging studies. Respondent’s assessment
included head concussion in the absence of a documented neurological examination. Respondent
failed to document what oral medication was either recommended or prescribed.

14. Respondent’s records document that he initially provided PT to FC on February 22,
2011. Respondent documented that he provided “therapy techniques,” electrical stimulation,
vasopneumatic device therapy, and diathermy treatment to FC for continued complaints of pain.
Respondent provided the same four PT modalities weekly in March 2011 (five times).
Thereafter, from April 2011 to January 2012, Respondent saw FC, on average, once or twice a
month and provided the same four PT modalities at each visit. 3 Respondent failed to document,
at any time, to which part of FC’s body the various PT modalities were applied, if there was a
response to the treatment and, if so, to which treatment. Respondent failed to consider and order
imaging studies to either confirm a diagnosis or when the patient failed to respond to PT
treatments.

15. Following the car accident in January 2011, FC complained of severe headache. On
March 29, 2011, FC saw Respondent and complained of headache. Blood pressure (BP) on this
date was 98/48, markedly low compared to FC’s prior BP measurements. BP was not repeated on
this date and Respondent did not instruct FC to follow-up regarding this abnormality.

3 Diathermy treatment was not provided on one visit in June 2011. No physical therapy
treatments are documented in November 2011.

16. At the initial visit on January 22, 2011 following the car accident, FC complained of severe headache, whole body pain, back/lumbar pain, and leg and knee pain. Over the course of PT treatments from February 2011 to January 2012, FC continued to variously complain of headaches, chest pain, back pain, and knee pain, at times reporting severe pain. Respondent failed to document a complete history and physical examination with a rating for the degree of pain FC reported initially and on subsequent visits. Respondent failed to assess and document FC’s pain levels, physical and psychological function, underlying or coexisting disease or conditions, and indications for treatment. Respondent provided prolonged PT and failed to consider, recommend, and/or to provide additional pharmacological treatments.

17. Respondent’s medical records for Patient FC contain copies of records for patients other than FC.

18. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2234 (b), and/or 2234 (c), and/or 2234 (d), and/or 725 of the Code in the Respondent was grossly negligent, and/or committed repeated negligent acts, and/or was incompetent, and/or provided excessive treatment in the practice of medicine in his care and treatment of Patient FC, including but not limited to the following:

   A. As FC’s primary care physician, Respondent failed to perform and document a complete history and physical examination of Patient FC.

   B. Respondent failed to chart a medical basis for his diagnoses of FC with depression, diabetes, and coronary artery disease. Nor did he chart any treatment for these conditions.

   C. Respondent failed to provide referrals and/or to document health care maintenance recommendations to FC, such as colon screening and mammography.
D. When FC was seen following involvement in a car accident, Respondent failed to perform and document a complete history and physical examination, including assessment of FC's pain levels, physical and psychological function, underlying or coexisting conditions, and indications for treatment.

E. Respondent failed to obtain the medical records of FC's ER visit following her involvement in the car accident.

F. Respondent failed to consider and order imaging studies in order to adequately assess and diagnose FC's complaints of back and knee pain, and headaches.

G. Respondent failed to perform a neurological examination in order to assess FC's ongoing complaints of headache and dizziness, and he failed to document a differential diagnosis and treatment options.

H. Respondent failed to document medical indication for PT treatments he provided to FC for 11 months.

I. Respondent failed to document to which parts of FC's body the various PT modalities were applied, and he failed to document FC's response to the PT treatments.

J. Respondent provided excessive PT treatments that are not supported by his documented history or progress notes.

K. Other than PT, Respondent failed to consider, recommend, and/or to provide FC with additional pharmacological treatments in response to her ongoing complaints of pain.

L. Respondent failed to document in the patient record all medications recommended and/or prescribed to FC.

SECOND CAUSE FOR DISCIPLINE

(Re: Patient KC)

(Unprofessional Conduct/Gross Negligence/Repeated Negligent Acts/Incompetence/Excessive Treatment)

19. Patient KC is a relative of Patient FC. Respondent's progress notes for Patient KC are sparse and often illegible. It appears that Patient KC, a 62-year-old woman, first saw
Respondent on May 7, 2007. In an extremely brief progress note, Respondent documented complaints of "poor concentration, depression, insomnia: x 3 months, and [history of] industrial injury." Portions of the note are illegible. It appears Respondent diagnosed depression and that his plan was medication. Respondent's records contain a copy of a prescription he wrote for KC on this date for Paxil 40 mg., #60, and Ambien 10 mg., #30. Respondent's records also contain a letter dated May 7, 2007 from him addressed "To Whom It May Concern," in which he certifies that he saw Patient KC that day. He further states that he diagnosed KC with "Major Depression and severe Insomnia" and that he prescribed Ambien and Paxil. Respondent's records for Patient KC do not contain documentation of a complete history and physical examination, summary of past medical history, review of symptoms, mental status examination, history of alcohol and drug use, nor history of prior treatment for depression.

20. Respondent's records contain documentation of a work-related injury KC suffered on April 25, 2006, in which she tripped over a wooden pallet, hit the left side of her body on a table, and fell to the ground. The records document that KC was diagnosed with a sprained left knee. An "Occupational Medicine Consultation" Report of June 26, 2006, states that KC continued to complain of weakness and pain in her left leg and back. The examiner opined, following examination of KC, that there was insufficient evidence to support KC's subjective complaints and that no additional treatment modalities were appropriate or necessary for the alleged injury. An "Internal Medicine/Occupational Medicine Disability Evaluation" Report of August 30, 2007, similarly states that KC's continued complaints of back pain radiating down her leg to the left knee were not explained on the basis of the injury. The examiner reported that KC's examination was negative for objective evidence of knee or back pathology and that KC's complaints of pain were out of proportion to the lack of physical findings.


on October 6, 2007. The Report states that KC was injured when she was struck on the top of her forehead by a wooden pole and that she suffered a headache. KC was taken to an emergency room where evaluation with blood tests and a CT scan were normal. The Report indicates that due to persistent headaches, KC was referred for neurological consultation. KC was determined to be, as of the date of the Report, permanent and stationary and she was discharged from further care.

23. Respondent’s records contain a prescription dated October 14, 2009 for Claritin (an antihistamine) 10 mg., #12, and doxycycline (an antibiotic) 100 mg., #20. There is no progress note for this date. A progress note for October 13, 2009 documents a complaint of left shoulder pain, but no complaint or symptoms of allergies or infection, and no assessment or treatment corresponding to the prescriptions given KC on October 14, 2009.

24. On January 22, 2011, Patient KC saw Respondent and reported being in a car accident on January 12, 2011. KC complained of lumbar pain and left knee and ankle pain. Respondent noted the patient’s past medical history included major depression and hallucination and that KC had a history of worker’s compensation claims. Respondent failed to perform and document a complete history and physical examination. Respondent documented a limited examination and diagnosed lumbar sprain/strain; cervical sprain/strain; lumbar radiculopathy; and, left knee, leg, and ankle pain. Respondent’s plan included x-rays, Motrin 600 mg., physical therapy (PT), and disability for two weeks. Respondent failed to document a history of KC’s previous worker’s compensation injuries, preexisting symptoms, current symptoms, and how the patient’s symptoms have changed since the car accident.

25. Respondent’s records contain copies of billings to KC for an ambulance and for Highland Hospital emergency room treatment on the date of the accident. The billings indicate that x-rays of the lumbar spine were taken and that KC was given hydrocodone/APAP for pain. Respondent’s records do not indicate that he ever requested nor obtained the medical records and imaging studies of KC’s emergency room visit. Respondent’s records for KC contain copies of billings to Patient FC for FC’s emergency room treatment.
26. Respondent’s records document that he initially provided PT to KC on February 22, 2011. KC received PT from Respondent four times in March 2011. Thereafter, from April 2011 to December 2011, Respondent performed PT treatments on KC approximately one to two times per month for continued complaints of pain. Respondent documented that he provided a combination of some of the following PT modalities at each visit: vasopneumatic device therapy, therapy techniques, electrical stimulation, diathermy treatment, ultrasound, medical traction therapy, and massage therapy. Respondent failed to document, at any time, to which part of KC’s body the various PT modalities were applied, if there was a response to the treatment and, if so, to which treatment. Respondent failed to consider and order imaging studies to either confirm a diagnosis or when the patient failed to respond to PT treatments. Respondent failed to consider and refer KC to a specialist when PT treatments failed to resolve her complaints of pain.

27. Respondent’s records document that on March 1, 2011 and October 4, 2011, KC complained of left ankle pain and that he performed trigger point injections to KC’s left ankle. Respondent failed to review past imaging studies or to obtain further imaging studies prior to performing the trigger point injections on March 1 and October 4, 2011.

28. Respondent’s records document that on March 29, 2011, KC complained of lumbar pain and limited range of motion and that he performed spinal nerve blocks to L2-3, L4-5, and L5-S1. Respondent repeated the same procedure to the same locations on August 2, 2011, when KC reported worsening symptoms after initially improving following the March 29, 2011 procedure. Respondent failed to review past imaging studies or to obtain further imaging studies prior to performing the spinal nerve blocks on March 29 and August 2, 2011. Respondent failed to adequately document the procedure used in performing the spinal nerve blocks.

29. Patient KC saw Respondent on March 22, 2011 and complained of fear and headaches in addition to lumbar, and cervical pain. Respondent’s diagnosis included post traumatic depression. Respondent’s records document that he diagnosed and at times treated Patient KC for depression beginning in 2007. Respondent’s records fail to contain pertinent history regarding KC’s depression, when the diagnosis was first made, her symptoms, whether she had been hospitalized due to depression, whether she has suicidal ideation currently or in the
past, whether she has been treated by other physicians for depression, and what are her current medication. Respondent failed to document a treatment plan for KC’s depression and he failed to included depression in his differential diagnosis as possibly causing or contributing to KC’s continued body pain.

30. At the initial visit on January 22, 2011 following the car accident, KC complained of lumbar and cervical pain, and left leg, knee, and ankle pain. Over the course Respondent’s treatment of Patient KC from February to December 2011, KC continued to variously complain of lumbar, leg, knee and ankle pain. Respondent failed to document a complete history and physical examination with a rating for the degree of pain KC reported initially and on subsequent visits. Respondent failed to assess and document KC’s pain levels, physical and psychological function, underlying or coexisting disease or conditions, and indications for treatment. Respondent provided prolonged PT and failed to consider, recommend, and/or to provide additional pharmacological treatments.

31. Respondent’s medical records for Patient KC contain copies of records for Patient FC.

32. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2234 (b), and/or 2234 (c), and/or 2234 (d), and/or 725 of the Code in the Respondent was grossly negligent, and/or committed repeated negligent acts, and/or was incompetent, and/or provided excessive treatment in the practice of medicine in his care and treatment of Patient KC, including but not limited to the following:

A. Respondent failed to, at any time, perform and document a complete history and physical examination of Patient KC.

B. When KC was seen following involvement in a car accident, Respondent failed to perform and document a complete history and physical examination, including assessment of KC’s pain levels, physical and psychological functioning, underlying or coexisting conditions, and indications for treatment.

C. Respondent failed to obtain the medical records of KC’s ER visit following her involvement in the car accident.
D. Respondent failed to consider and order imaging studies in order to adequately assess and diagnose KC’s complaints of lumbar, knee, leg, and ankle pain, and prior to performing trigger point injections and spinal nerve blocks.

E. Respondent failed to fully evaluate and treat KC’s symptoms of depression.

F. Respondent failed to include depression in his differential diagnosis as possibly causing or contributing to KC’s continued body pain.

G. Respondent failed to document medical indication for PT treatment he provided to KC for approximately 11 months.

H. Respondent failed to document to which parts of KC’s body the various PT modalities were applied, and he failed to document KC’s response to the PT treatments.

I. Respondent provided excessive PT treatments that are not supported by his documented history or progress notes.

J. Respondent failed to consider and refer KC to a specialist when the PT treatments failed to resolve her complaints of pain.

K. Respondent failed to consider, recommend, and/or to provide KC with additional pharmacological treatments in response to her ongoing complaints of pain.

THIRD CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

33. The allegations of the First and Second Causes for Discipline, above, are incorporated herein by reference as if fully set forth.

34. Respondent’s certificate to practice medicine is subject to disciplinary action for unprofessional conduct under Business and Professions Code section 2234, subdivision (c), for repeated negligent acts in his care and treatment of Patients FC and KC.

FOURTH CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Records)
35. The allegations of the First and Second Causes for Discipline, above, are incorporated herein by reference as if fully set forth.

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36. Respondent's certificate to practice medicine is subject to disciplinary action for unprofessional conduct under Business and Professions Code section 2266 for failure to maintain adequate and accurate records.

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 A 53395, issued to Frank Yun Jia Zhang, M.D.;

2. Revoking, suspending or denying approval of Frank Yun Jia Zhang, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Frank Yun Jia Zhang, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and,

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

DATED: April 24, 2015

[Signature]

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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