



New York State Board for Professional Medical Conduct

433 River Street, Suite 303 • Troy, New York 12180-2299 • (518) 402-0863

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
*Commissioner
NYS Department of Health*

Dennis P. Whalen
*Executive Deputy Commissioner
NYS Department of Health*

Dennis J. Graziano, Director
Office of Professional Medical Conduct

PUBLIC

Michael A. Gonzalez, R.P.A.
Vice Chair

Ansel R. Marks, M.D., J.D.
Executive Secretary

February 27, 2004

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Cynthia L. Quattro, R.P.A.

REDACTED

Re: License No. 003145

Dear Dr. Quattro:

Enclosed please find Order #BPMC 04-40 of the New York State Board for Professional Medical Conduct. This order and any penalty provided therein goes into effect March 5, 2004.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order to the Board for Professional Medical Conduct, New York State Department of Health, Hedley Park Place, Suite 303, 433 River Street, Troy, New York 12180.

Sincerely,

REDACTED

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

SURRENDER

OF

ORDER

**CYNTHIA LOUISE QUATTRO, R.P.A.
CO-03-11-5217-A**

BPMC No. 04-40

CYNTHIA LOUISE QUATTRO, R.P.A., says:

On or about November 10, 1986, I was licensed to practice medicine as a physician assistant in the State of New York having been issued License No. 003145 by the New York State Education Department. I currently reside at REDACTED

I am not currently registered with the New York State Education Department to practice as a physician assistant in the State of New York.

I understand that the New York State Board for Professional Medical Conduct has charged me with two (2) specifications of professional misconduct as set forth in the Statement of Charges, annexed hereto, made a part hereof, and marked as Exhibit "A."

I am applying to the State Board for Professional Medical Conduct for an agreement to allow me to surrender my license as a physician assistant in the State of New York and request that the Board issue this Surrender Order.

I, hereby, agree not to contest the two (2) specifications set forth in the Statement of Charges (Exhibit A).

I understand that in the event that this proposed agreement is not granted by the State Board for Professional Medical Conduct, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such proposed agreement shall not be used against me in any way, and shall be kept in strict

confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the State Board for Professional Medical Conduct shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by a Committee on Professional Medical Conduct pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Order to me at the address set forth above or to my attorney or upon transmission via facsimile to me or my attorney, whichever is first.

I am making this agreement of my own free will and accord and not under duress, compulsion or restraint of any kind of manner.

Date: 2/9, 2004

REDACTED

CYNTHIA LOUISE QUATTOR, R.P.A.
Respondent RO

AGREED TO:

Date: 17 February, 2004

REDACTED

ROBERT BOGAN
Associate Counsel
Bureau of Professional Medical Conduct

Date: 23 February, 2004

REDACTED

DENNIS J. GRAZIANO
Director, Office of Professional
Medical Conduct

STATE OF NEW YORK

DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

STATEMENT

OF

OF

CYNTHIA LOUISE QUATTRO, R.P.A.
CO-03-11-5217-A

CHARGES

CYNTHIA LOUISE QUATTRO, R.P.A., the Respondent, was authorized to practice as a physician assistant in New York state on November 10, 1986, by the issuance of license number 003145 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about October 1, 2003, the Physician Assistant Committee, Medical Board of California, Department of Consumer Affairs, (hereinafter "California Board") by a Decision and Order (hereinafter "California Order"), revoked Respondent's Physician Assistant License, stayed the revocation and placed her on three (3) years probation, with terms and conditions, that include that she successfully complete thirty (30) hours CME, that her practice to be monitored by a supervising physician, and that she pay \$3,500.00 investigative costs, based on failure to perform an adequate or any physical examination on a patient, and proceeded with Photoluminescence Therapy on the patient without providing and/or documenting adequate or any informal consent.

B. The conduct resulting in the California Board disciplinary action against Respondent would constitutes misconduct under the laws of New York state, pursuant to the following sections of New York state Law:

1. New York Education Law §6530(32) (failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient).

SPECIFICATIONS
FIRST SPECIFICATION

Respondent violated New York Education Law §6530(9)(b) having been found guilty of improper professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct upon which the finding was based would, if committed in New York state, constitute professional misconduct under the laws of New York state, in that Petitioner charges:

1. The facts in Paragraphs A and/or B.

SECOND SPECIFICATION

Respondent violated New York Education Law §6530(9)(d) by having her license to practice medicine revoked or having other disciplinary action taken by a duly authorized professional disciplinary agency of another state, where the conduct resulting in the revocation or other disciplinary action would, if committed in New York state, constitute professional misconduct under the laws New York state, in that Petitioner charges:

2. The facts in Paragraphs A and/or B.

DATED: *February 11*, 2004
Albany, New York

REDACTED

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical Conduct

ORDER

Upon the proposed agreement of **CYNTHIA LOUISE QUATTRO, R.P.A.**, to Surrender her license as a physician assistant in the State of New York, which proposed agreement is made a part hereof, it is **AGREED TO** and

ORDERED, that the proposed agreement and the provisions thereof are hereby adopted; it is further

ORDERED, that the name of the Respondent be stricken from the roster of physician assistants in the State of New York; it is further

ORDERED, that this Order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy to Respondent at the addresses set forth in this agreement or to Respondent's attorney or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

DATED: 2/26, 2004

REDACTED

MICHAEL A. GONZÁLEZ, R.P.A.
Vice Chair
State Board for Professional
Medical Conduct



BEFORE THE
PHYSICIAN ASSISTANT COMMITTEE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation)
Against:)
)
CYNTHIA LOUISE QUATTRO, P.A.)
)
)
Physician Assistant)
License No. PA-12134)
)
Respondent.)
_____)

Case No: 1E-2001-117845

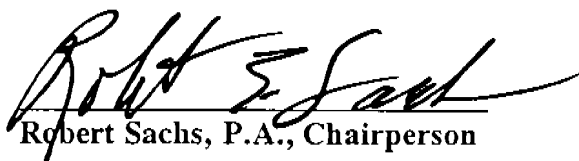
DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby accepted and adopted as the Decision and Order by the Physician Assistant Committee, Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on October 31, 2003

ORDERED October 1, 2003

PHYSICIAN ASSISTANT COMMITTEE


Robert Sachs, P.A., Chairperson

1 BILL LOCKYER, Attorney General
of the State of California
2 VIVIEN HARA
Supervising Deputy Attorney General
3 RUSSELL W. LEE, State Bar No. 094106
Deputy Attorney General
4 California Department of Justice
1515 Clay Street, 20th Floor
5 P.O. Box 70550
Oakland, CA 94612-0550
6 Telephone: (510) 622-2217
Facsimile: (510) 622-2121
7

8 Attorneys for Complainant

9
10 **BEFORE THE**
PHYSICIAN ASSISTANT COMMITTEE OF
THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 1E-01-117845

13 **CYNTHIA LOUISE QUATTRO, P.A.**
20 Hatton Avenue
14 Watsonville, CA 95076

STIPULATED SETTLEMENT
AND DISCIPLINARY ORDER

15 Physician Assistant License No. PA-12134

16
17 Respondent.

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

20 1. Complainant, Richard L. Wallinder, Jr., is the Executive Officer of the
21 Physician Assistant Committee of the Medical Board of California, Department of Consumer
22 Affairs, State of California (hereinafter "complainant") and is represented by Bill Lockyer,
23 Attorney General of the State of California by Russell W. Lee, Deputy Attorney General.

24 2. Cynthia Louise Quattro P.A., ("respondent") is represented in this matter
25 by Philip Lincoln Buckwalter, Esq., Attorney At Law, 9053 Soquel Drive, Suite 206, Aptos, CA
26 95003 (831) 688-0163. Respondent has counseled with her attorney concerning the effect of this
27 Stipulated Settlement and Disciplinary Order ("stipulation") which respondent has carefully read
28 and fully understands.

1 3. Respondent has received and read the Accusation which is presently on
2 file and pending in Case Number 1E-01-117845 before the Physician Assistant Committee of the
3 Medical Board of California, Department of Consumer Affairs, State of California (hereinafter
4 "Committee"), a copy of which is attached as Exhibit A and incorporated herein by reference.

5 4. Respondent understands the nature of the charges alleged in the
6 Accusation and that, if proven at hearing, such charges and allegations would constitute cause for
7 imposing discipline upon respondent's license issued by the Committee. Respondent and her
8 counsel are aware of each of respondent's rights, including the right to a hearing on the charges
9 and allegations, the right to confront and cross-examine witnesses who would testify against
10 respondent, the right to testify and present evidence on her own behalf, as well as to the issuance
11 of subpoenas to compel the attendance of witnesses and the production of documents, the right to
12 contest the charges and allegations, and other rights which are accorded respondent pursuant to
13 the California Administrative Procedure Act (Gov. Code, § 11500 et seq.) and other applicable
14 laws, including the right to seek reconsideration, review by the superior court, and appellate
15 review.

16 5. In order to avoid the expense and uncertainty of a hearing, respondent
17 freely and voluntarily waives each and every one of these rights set forth above. Respondent
18 admits and agrees that cause exists to discipline Physician Assistant License No. PA-12134 for
19 unprofessional conduct pursuant to sections 2234 and 3527 of the Business and Professions
20 Code, in conjunction with section 1399.521 of Title 16 of the California Code of Regulations, in
21 that respondent committed the following acts or omissions in relation to her treatment of Patient
22 A.: Respondent failed to perform an adequate or any physical examination; and respondent
23 proceeded with Photoluminescence Therapy on Patient A. without providing and/or documenting
24 adequate or any informed consent.

25 6. Respondent understands that by signing this stipulation, she is enabling the
26 Committee to issue its order imposing disciplinary action upon her license without further
27 process. Respondent understands and agrees that Committee staff and counsel for complainant
28 may communicate directly with the Committee regarding this stipulation, without notice to or

1 participation by respondent or her counsel. In the event that this stipulation is rejected for any
2 reason by the Committee, it will be of no force or effect for either party. The Committee will
3 not be disqualified from further action in this matter by virtue of its consideration of this
4 stipulation.

5 7. Based on the foregoing admissions and stipulated matters, the parties agree
6 that the Committee shall, without further notice or formal proceeding, issue and enter the
7 following order:

8 **DISCIPLINARY ORDER**

9 **IT IS HEREBY ORDERED** that Physician Assistant License No. PA-12134
10 issued to respondent Cynthia Louise Quattro P.A. is revoked. However, said revocation is stayed
11 and respondent is placed on probation for three (3) years on the following terms and conditions:

12 **A. Education Course**

13 Within 90 days of the effective date of the decision, and on an annual basis
14 thereafter, if necessary, respondent shall submit to the Physician Assistant Committee or its
15 designee for its prior approval an educational program or course from an accredited program
16 which shall not be less than 30 hours of Category 1 CME, which shall include the study of
17 intravenous technique, complications related to blood clotting, and interpretation and treatment
18 of hypothyroidism. Respondent shall participate in the education course at her own expense.
19 Respondent shall provide proof of attendance and satisfactory completion of the continuing
20 medical education. If Category 1 CME courses for physician assistants are unavailable in the
21 subject areas indicated above, respondent may submit to the Physician Assistant Committee or its
22 designee for its prior approval accredited CME courses approved for other health care licensees
23 in California, and/or other college or post graduate level courses covering the said subject areas.
24 A total of 30 hours of CME is required. The 30 hour total may be met by attending several
25 separate classes. It is understood that the classes may only be offered at specific times and
26 locations which may take longer than one year to complete.

27 **B. Monitoring / Supervision**

28 Within 30 days of the effective date of this decision, respondent shall submit to

1 the committee or its designee for its prior approval a plan of practice in which respondent's
2 practice shall be monitored by a supervising physician responsible for patients treated by the
3 physician assistant.

4 If the supervising physician/monitor resigns or is no longer available, respondent
5 shall, within 15 days, move to have a new supervising physician/monitor appointed, through
6 nomination by respondent and approval by the committee.

7 Respondent shall not practice as a physician assistant until supervising physician
8 is approved by the committee.

9 **C. Obey All Laws**

10 Respondent shall obey all federal, state, and local laws, and all rules governing the
11 practice of medicine as a physician assistant in California and remain in full compliance with any
12 court ordered criminal probation, payments, and other orders.

13 **D. Quarterly Reports**

14 Respondent shall submit quarterly declarations under penalty of perjury on forms
15 provided by the committee or its designee, stating whether there has been compliance with all the
16 conditions of probation.

17 **E. Probation Surveillance Program Compliance**

18 Respondent shall comply with the committee's probation surveillance program.
19 Respondent shall, at all times, keep the committee informed of her addresses of business and
20 residence which shall both serve as addresses of record. Changes of such addresses shall be
21 immediately communicated in writing to the committee. Under no circumstances shall a post
22 office box serve as an address of record, except as allowed by California Code of Regulations
23 1399.523.

24 Respondent shall, at all times, maintain a current and renewed physician assistant
25 license.

26 Respondent shall also immediately inform the committee, in writing, of any travel
27 to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more
28 than thirty (30) days.

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F. Interview with Medical Consultant

Respondent shall appear in person for interviews with the committee's medical or expert physician assistant consultant upon request at various intervals and with reasonable notice.

G. Tolling for Out-of-State Practice or Residence

The period of probation shall not run during the time respondent is residing or practicing outside the jurisdiction of California. If, during probation, respondent moves out of the jurisdiction of California to reside or practice elsewhere, including federal facilities, respondent is required to immediately notify the committee in writing of the date of departure, and the date of return, if any.

H. Initial Probation Interview

Respondent shall appear in person for an initial interview with a designee of the PAC within 90 days of the final decision. Respondent shall subject himself/herself to an initial interview at a time and place determined by the committee or its designee.

I. Unannounced Clinical Site Visit

At least once per calendar year or more frequently as determined by the committee or its designee unannounced clinical site visits by shall be made by the committee or its designee to ensure that respondent is complying with all terms and conditions of probation.

J. Completion of Probation

Upon successful completion of probation as determined by the committee's executive officer, respondent's license will be fully restored.

K. Violation of Probation

If respondent violates probation in any respect, the committee 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 or petition to revoke probation is filed against respondent during probation, the committee shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

L. Cost Recovery

The respondent is hereby ordered to reimburse the Physician Assistant Committee

1 the amount of \$3,500.00 within 90 days from the effective date of this decision for its
2 investigative costs. Failure to reimburse the committee's costs for its investigation shall
3 constitute a violation of the probation order, unless the committee agrees in writing to payment
4 by an installment plan because of financial hardship. The filing of bankruptcy by the respondent
5 shall not relieve the respondent of his/her responsibility to reimburse the committee for its
6 investigative costs.

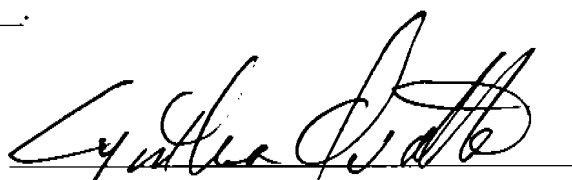
7 **M. Voluntary License Surrender**

8 Following the effective date of this probation, if respondent ceases practicing due
9 to retirement, health reasons, or is otherwise unable to satisfy the terms and conditions of
10 probation, respondent may voluntarily tender his/her license to the committee. The committee
11 reserves the right to evaluate the respondent's request and to exercise its discretion whether to
12 grant the request, or to take any other action deemed appropriate and reasonable under the
13 circumstances. Upon formal acceptance of the tendered license, respondent will no longer be
14 subject to the terms and conditions of probation.

15 **ACCEPTANCE**

16 I, Cynthia Louise Quattro P.A., have read the above Stipulated Settlement and
17 Disciplinary Order. I have fully discussed the terms and conditions and other matters contained
18 therein with my attorney. I understand the effect this Stipulated Settlement and Disciplinary
19 Order will have on my Physician Assistant License No. PA-12134, and agree to be bound
20 thereby. I enter this stipulation freely, knowingly, intelligently and voluntarily.

21 DATED: 8/27/03.



CYNTHIA LOUISE QUATTRO, P.A.
Respondent

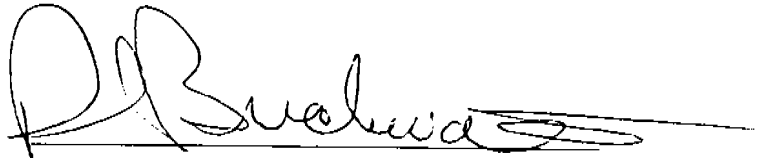
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1 I have read the above Stipulation Settlement and Decision and approve of it as to
2 form and content. I have fully discussed the terms and conditions and other matters therein with
3 respondent.

4 DATED: 9/2/03

5
6 

7
8 PHILIP LINCOLN BUCKWALTER, ESQ.
9 Attorney for Respondent

10
11 **ENDORSEMENT**

12 The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully
13 submitted for consideration of the Physician Assistant Committee of the Medical Board of
14 California, Department of Consumer Affairs.

15
16 DATED: 9-4-03

17
18 BILL LOCKYER, Attorney General
19 of the State of California

20 

21 RUSSELL W. LEE
22 Deputy Attorney General

EXHIBIT A

FILED

STATE OF CALIFORNIA

MEDICAL BOARD OF CALIFORNIA

SACRAMENTO March 3, 2003
BY Allen Berganti ANALYST

1 BILL LOCKYER, Attorney General
of the State of California
2 VIVIEN HARA
Supervising Deputy Attorney General
3 RUSSELL W. LEE (State Bar No. 094106)
Deputy Attorney General
4 California Department of Justice
1515 Clay Street, Suite 2000
5 P.O. Box 70550
Oakland, California 94612-0550
6 Telephone: (510) 622-2217
Facsimile: (510) 622-2121

7 Attorneys for Complainant

8
9 BEFORE THE
PHYSICIAN ASSISTANT COMMITTEE OF
10 THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
11 STATE OF CALIFORNIA

12 In the Matter of the Accusation Against:

Case No.: 1E-01-117845

13 **CYNTHIA LOUISE QUATTRO, P.A.**
20 Hatton Avenue
14 Watsonville, CA 95076
15 Physician Assistant License No. 12134

ACCUSATION

16 Respondent.

17
18 The Complainant alleges:

19 **PARTIES**

20 1. Complainant, Richard L. Wallinder, Jr., is the Executive Officer of the
21 Physician Assistant Committee of the Medical Board of California, Department of Consumer
22 Affairs, State of California (hereinafter "the Committee") and brings this Accusation solely in his
23 official capacity.

24 2. On or about April 1, 1988, Physician Assistant License No. PA-12134 was
25 issued by the Committee to Cynthia Louise Quattro (hereinafter "respondent" or "Quattro").
26 Respondent's license, if not renewed, will expire on February 29, 2004.

1 JURISDICTION

2 3. Section 3504 of the Business and Professions Code (hereinafter referred to
3 as "the Code") provides for the existence of the Committee within the Medical Board of
4 California (hereinafter "the Board").

5 4 Section 3527 of the Code provides, in pertinent part, that the Committee
6 may order the suspension or revocation of, or the imposition of probationary conditions upon a
7 physician assistant license after a hearing as required in Section 3528 for unprofessional conduct
8 which includes, but is not limited to a violation of this chapter (Chapter 7.7, §3500, *et seq.* of the
9 Business and Professions Code), a violation of the Medical Practice Act (Business and
10 Professions Code §2000 *et seq.*) or a violation of the regulations adopted by the Committee or
11 the Board.

12 5. Section 1399.521 of Title 16 of the California Code of Regulations
13 provides, in pertinent part, as follows:

14 "In addition to the grounds set forth in Section 3527, subd. (a), of the code,
15 the committee may ... suspend, revoke, or place on probation a physician's assistant for the
16 following causes:

17 (a) Any violation of the State Medical Practice Act which would
18 constitute unprofessional conduct for a physician and surgeon.

19 ...

20 (e) Performing medical tasks which exceed the scope of practice of a
21 physician assistant as prescribed in these regulations."

22 6. Section 2234 of the Code provides, in pertinent part, that the Division of
23 Medical Quality of the Medical Board of California shall take action against any licensee who is
24 charged with unprofessional conduct. Unprofessional conduct includes, but is not limited to, the
25 following:

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

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- (b) Gross negligence.
- (c) Repeated Negligent Acts
- (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.”

7. Section 2242(a) of the Code (Medical Practice Act) provides that the prescribing, dispensing, or furnishing of dangerous drugs as defined in section 4022 of the Code without a good faith prior examination and medical indication therefor, constitutes unprofessional conduct for a physician and surgeon, and through section 3527 of the Code, for a physician assistant.

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that in any order issued in resolution of a disciplinary proceeding before any board within the California Department of Consumer Affairs, the Board may request the administrative law judge to direct a licensee found to have committed a violation/violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL ALLEGATIONS

9. This case was initiated based on a consumer complaint from Patient A.^{1/}, a 50 year old male. Investigation revealed as follows:

A. Patient A. had been a patient of Dr. Randy Baker in Soquel, wherein Cindy Quattro, P.A., functioned as a physician assistant. Patient A. had seen brochures in their office regarding a procedure called "photoluminescence" or "UVPL" which they claimed was good for hepatitis C, cancer, aids, candida, worms, amoebas and parasites.

B. Patient A. scheduled an initial appointment with Quattro on or about

1. The name of the patient will be disclosed upon a proper request for discovery.

1 7/27/2000. Quattro took a medical history and performed routine blood tests on Patient A..
2 These tests included a lipid profile; complete blood count; PSA; thyroid functions' blood typing;
3 chemistry panel and DHEA-S levels. Quattro approved Patient A. for UVPL treatment. A
4 physical examination of Patient A. was not performed and Quattro later explained in an interview
5 with the Medical Board on 3/22/02 that while physical exams are routinely done prior to
6 treatment, Patient A.'s physical examination had "slipped through the cracks". During said
7 interview, Quattro also indicated that she did not discuss the risks and benefits of the UPVL
8 treatments with Patient A..

9 C. During a second visit with Patient A.,(which occurred after Patient
10 A underwent several UVPL treatments by a nurse), which Quattro recorded as being on 9/18/00,
11 Quattro gave Patient A. a thyroid supplementation medication based upon the results of the
12 previous blood tests that Quattro interpreted as indicating borderline hypothyroidism. In truth
13 and in fact, no evidence was presented in the record to indicate hypothyroidism and Patient A.'s
14 thyroid function studies were all well within normal limits. Quattro did not perform a physical
15 examination on Patient A. during this visit either.

16 D. After the initial visit with Quattro, Patient A. was scheduled for
17 and underwent approximately nine UVPL treatments, performed by a nurse, on or about
18 8/1/2000, 8/15/2000, 8/22/2000, 9/12/2000, 9/15/2000, 9/22/2000, 9/29/2000, 10/6/2000, and
19 10/13/2000. The UVPL procedure involved the nurse taking about 200 cc of blood from Patient
20 A., running the blood through an ultraviolet light machine, and then returning it to Patient A.'s
21 body.

22 E. In his complaint to the Medical Board, Patient A. indicated, inter
23 alia, as follows: the nurse, "Stacy Smith", became alarmed as the weeks went by because Patient
24 A. was experiencing a greater and greater degree of "blood clotting". Ms. Smith began leaving
25 notes of concern for Quattro and written messages in her medical log. Quattro never responded
26 to Patient A. regarding the clotting concerns expressed by Ms. Smith. The blood clotting
27 continued to elevate and the nurse continued to inform Quattro of the problem. On the last
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1 session the blood clotting got so bad that the tubing broke, causing blood to scatter all over the
2 room. The nurse refused to continue with the procedure and immediately called Dr. Baker on
3 Friday afternoon, 10/13/00. By late that afternoon, Patient A. was experiencing weakness and
4 constriction in his chest, shortness of breath and heart palpitations. On the next Monday he still
5 had not heard from Dr. Baker or Quattro. He called the office twice that day and left messages.
6 Dr. Baker returned his call at 10:00 p.m. that night and told him that blood clots were not
7 uncommon and that he would order special blood tests from Arizona. Dr. Baker called him again
8 on Tuesday and was told of his symptoms. He did not hear from Dr. Baker for over a month and
9 then only after he wrote a letter of complaint about their negligence. In or about December, Dr.
10 Baker and Quattro began having long phone conversations with Patient A.. In the final
11 conversation with Quattro, Patient A. confronted her about the nurse's notes and the blood
12 clotting which occurred during the procedures. Quattro responded "I did not take it seriously".
13 Dr. Baker said he felt sorry for what happened to Patient A. but takes no responsibility for the
14 effects of the experimental procedure. He insisted that "Russian doctors found significant
15 improvement in 137 out of 145 patients".

16 F. The notes kept by nurse Smith reference problems with clotting in
17 tubing on 8/1/00, 8/15/00, 9/15/00, 9/22/00, and 9/29/00, and on 10/13/00, severe clotting was
18 noted.

19 G. On or about 11/6/01, nurse Stacy Smith- Paynter ("Smith") was
20 interviewed by a Medical Board Investigator. Nurse Smith indicated, inter alia, as follows: The
21 Photoluminescence machine was not in the office when she was first employed by Dr. Baker. She
22 was trained by Dr. Baker in the process necessary to complete the treatments. She described it
23 simply as "a small square box" that fits on the top of a small table. The tube from the patient's
24 arm is laid across the top of a light bar on top of the machine where the blood passed over the
25 light and on to a bag where the blood is held after passing over the light. The blood is then
26 released back into the patient's arm as if it were a blood transfusion. She said that the amount of
27 blood passed over the light and then back to the patient is 150 to 200 cc. She referred to the
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1 treatment as Ultraviolet Blood Irradiation. She worked part time at Dr. Baker's office and
2 normally did two to five procedures on the days she did work. If she was not there, Dr. Baker
3 performed the procedures. The only unusual occurrence with the procedure while she worked
4 there occurred when she was treating Patient A.. He had a blood clotting problem which
5 occasionally made the procedure more difficult. On one particular day, the clotting was severe
6 and she was attempting to flush the line from Patient A.'s arm. She continued to flush the line
7 but a clip was dislodged and the blood splattered on the floor, on her and a co-worker. She
8 stopped the procedure and advised Patient A. to see his primary care physician. She recalls
9 leaving a note for Quattro regarding the clotting problem but Quattro denied seeing the note.

10 H. On or about 03/22/02, Quattro was interviewed by a Medical
11 Board Investigator and a Medical Consultant. Quattro indicated, inter alia, as follows: Patient A.
12 called the clinic, stating that he wanted to have the UPVL treatments. When he came in he had
13 no specific medical complaints, other than minor irritable bowel syndrome and suffering from "a
14 lack of energy". Patient A. did fill out his own patient history form, noting that he had a family
15 history (grandfather) of heart disease. He mentioned that he wanted to go through the treatment
16 as he was turning fifty years of age. Quattro stated that she did not perform a physical exam, as
17 "...it fell through the cracks." She normally conducts an exam on the first visit, or on the second
18 if for some reason it is not done on the first visit. Patient A. never came back for the "second
19 visit" instead calling the office (repeatedly) and demanding his lab results. Quattro finally spoke
20 with him by telephone and gave him the results. Patient A. was then scheduled to start the
21 treatments. She explained to him the process of UPVL, however she stated that he seemed to
22 already know about the topic and was certain that he wanted the treatments. She took his
23 medical complaints into account and ordered a thyroid test. She did not perform a physical
24 examination on either of the two visits. Quattro stated that Patient A. appeared very happy with
25 his first five sessions, and subsequently requested additional treatments. Quattro did not discuss
26 the risks and benefits of the UPVL treatments with Patient A.. At the conclusion of the first five
27 treatments, it is the office protocol to have the patient return for a review visit. Patient A. did in
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1 fact come in for the follow up. On that occasion he did mention his concern about his blood
2 clotting. They also discussed his high cholesterol. She recommended a "Omega 3 fatty acids
3 fish oil" which is sold in the office. On this return visit, she gave Patient A. a thyroid extract
4 medication. She was certain that he was satisfied with the procedures and the office visit up to
5 that point. Regarding the blood clotting, she did not believe that his was an unusual problem as
6 the blood is slow moving through the tube, therefore she did not believe that he had an unusual
7 pathology. When questioned during her interview regarding the issue of the blood clotting in the
8 tubing, Quattro stated that she did not believe that the patient was at any risk because they only
9 use a 19 gauge needle and this prevents clots from reentering the patient's body. Patient A.'s last
10 treatment was on a Friday. Quattro stated that she went on vacation that Saturday, receiving a
11 message on the following Wednesday, while in Colorado. She did not hear from Mr. Patient A.
12 on her message line and was not told by the front office that he wanted to speak with her directly.
13 While she was out of town, Dr. Baker was covering her patients for her.

14 I. In an earlier letter to the Medical Board February 26, 2001, Quattro
15 indicated, inter alia, as follows: We performed routine blood tests, which included a lipid
16 profile, CBC and PSA. The results revealed mild hyperlipidemia, a low cardiac risk factor and a
17 normal platelet count. We require our patients to have a follow visit to discuss lab results and
18 offer recommendations. Respondent refused to come in for this follow-up visit but called several
19 times demanding his test results, insisting he had the right to have them. I did leave a message
20 for him reviewing the primary results of his tests and encouraged him to schedule a visit so we
21 could further discuss them. I approved the UVPL procedure and, when he came for his
22 treatment, he insisted on a copy of his lab results which he was given. I don't recall precisely
23 when Stacy Smith, the RN, wrote me one undated note on a yellow post-it and placed it in my
24 message box stating that respondent had experienced some clotting during his procedure.
25 Knowing that some of our other patients have experienced clotting during this procedure and,
26 having experience myself performing a similar type of procedure in the past, I understood the
27 sometimes challenging task of removing blood and returning it through the same needle without
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1 experiencing some clotting in between. I did not interpret this note to indicate anything out of
2 the ordinary regarding the clotting. In retrospect, perhaps I could have assured nurse Smith that
3 this can be a common event during this procedure and remind her that the clotting is highly
4 dependent on how well the needle is placed, how long it takes to draw the blood through the
5 tubing, how quickly it flows through the tubing, and if there is an adequate amount of heparin in
6 the line. Routinely, we require a follow-up visit after five treatments to reassess the progress
7 after the treatments. I was pleased respondent agreed to follow through with a review visit. He
8 was enthusiastic about his treatments, had no other complaints, and requested another series of
9 them. He said his energy had noticeably improved. I suggested he take Omega 3 fatty acid to
10 help regulate his cholesterol and to thin the blood. I also recommended a trial of low dose
11 "Westroid" since his TSH was in the upper range of normal with which Dr. Baker concurs. No
12 herbs were prescribed. Respondent seemed satisfied with our visit and scheduled for additional
13 UVPL treatments. I did not receive any additional notes regarding unusual clotting from nurse
14 Smith during the next set of treatment which she also confirmed with me after speaking to her
15 about it.

16 ACTS OR OMISSIONS

17 10. Respondent committed the following acts or omissions in relation to his
18 treatment of Patient A.:

- 19 A. Respondent failed to perform an adequate or any physical
20 examination; and/or
- 21 B. Respondent proceeded with Photoluminescence Therapy on Patient
22 A., based upon routine laboratory tests and a history; and/or
- 23 C. Respondent proceeded with Photoluminescence Therapy on Patient
24 A., without providing and/or documenting adequate or any informed consent; and/or
- 25 D. Quattro failed to ascertain the quality or extent of the reported
26 clotting in the tubing during the UVPL treatments, including, but not limited to, discussing the
27 issue with nurse Smith, and/or supervising nurse Smith, and/or reviewing nurse Smith's patient
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1 notes, and/or personally observing the treatment sessions to determine whether the clotting was
2 extensive enough to pose a physical danger to Patient A.; and/or

3 E. Quattro improperly assumed that a 19 gauge needle was adequate
4 to prevent any complications related to clotting; and/or

5 F. Quattro recommended or prescribed or dispensed medications for
6 hypothyroidism, to wit, Armour Thyroid, a dangerous drugs as defined in section 4022 of the
7 Code, based upon a determination that Patient A.'s TSH value was in the "upper range of
8 normal", and/or without doing a physical examination. In truth and in fact, Patient A.'s thyroid
9 function studies were all well within normal limits; and/or

10 VIOLATIONS

11 11. Respondent's conduct as set forth paragraphs 9 and 10, hereinabove,
12 constitutes general unprofessional conduct and is cause for disciplinary action pursuant to
13 sections 2234 and 3527 of the Code, in conjunction with section 1399.521 of Title 16 of the
14 California Code of Regulations.

15 12. Respondent's conduct as set forth in paragraphs 9 and 10, hereinabove,
16 constitutes gross negligence and is cause for disciplinary action pursuant to sections 2234(b) and
17 3527 of the Code, in conjunction with section 1399.521 of Title 16 of the California Code of
18 Regulations.

19 13. Respondent's conduct as set forth in paragraphs 9 and 10, hereinabove
20 constitutes incompetence and is cause for disciplinary action pursuant to sections 2234(d) and
21 3527 of the Code, in conjunction with section 1399.521 of Title 16 of the California Code of
22 Regulations.

23 14. Respondent's conduct, as alleged in paragraph 9 and 10, hereinabove,
24 constitutes a violation of section 2242(a) of the Code in that respondent prescribed medications
25 (Armour Thyroid) without a good faith prior examination and medical indication therefor.
26 Therefore, cause exists for discipline pursuant to section 3527 of the Code.

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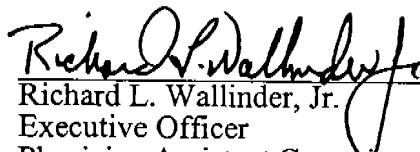
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PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Committee issue a decision:

1. Revoking or suspending Physician Assistant License Number PA 12134 heretofore issued to respondent Cynthia Louise Quattro;
2. Ordering respondent to pay the Committee the actual and reasonable costs of the investigation and enforcement of this case;
3. If probation is included in any order issued herein, to order respondent to pay the costs of probation; and
4. Taking such other and further action as the Committee deems necessary and proper.

DATED: March 3, 2003


Richard L. Wallinder, Jr.
Executive Officer
Physician Assistant Committee of the
Medical Board of California
Department of Consumer Affairs
State of California

Complainant