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

PUBLIC

IN THE MATTER

OF

JANE ESPEJO NORTON, M.D.
CO-04-11-5693-A

COMMISSIONER'S SUMMARY ORDER

TO: JANE ESPEJO NORTON, M.D.
HOR
80-329 Green Hills Drive
Indio, CA 92201

JANE ESPEJO NORTON, M.D.
148 Jack Road
Cortlandt Manor, NY 10567-0000

[redacted]

JANE ESPEJO NORTON, M.D.
Desert Island Building, 910
Apt. 503
Rancho Mirage, CA 92260

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73 345 US Highway 111
Suite 205
Palm Desert, CA 92260

JANE ESPEJO NORTON, M.D.
71-133 El Paseo
Suite 6
Palm Desert, CA 92260

JANE ESPEJO NORTON, M.D.
25 Sutton Place S 9N
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JANE ESPEJO NORTON, M.D.
74-361 Highway 11
Palm Desert, CA 92260

JANE ESPEJO NORTON, M.D.
74-090 El Paseo Drive
Suite 100
Palm Desert, CA 92260

JANE ESPEJO NORTON, M. D.
J Norton MD, PC
The Corporation
109 E 61st Street
New York, NY 10021

The undersigned, Antonia C. Novello, M.D., M.P.H., Dr. P.H., Commissioner of Health, pursuant to N.Y. Public Health Law §230, upon the recommendation of a committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, has determined that the duly authorized professional disciplinary agency of another jurisdiction, the State of California, Division of Medical Quality, Medical Board of California, Department of Consumer Affairs, (hereinafter "California Board") has made a finding substantially equivalent to a finding that the practice of medicine by **JANE**

ESPEJO NORTON, M.D., Respondent, licensed to practice medicine in New York state on March 3, 1999, by license number 213382, in that jurisdiction, constitutes an imminent danger to the health, safety, and welfare of its people, as is more fully set forth in documents of the State of California, attached hereto, as "Appendix A," and made a part hereof.

It is, therefore:

ORDERED, pursuant to N.Y. Public Health Law Section 230(12)(b), that effective immediately, **JANE ESPEJO NORTON, M.D.**, Respondent, shall not practice medicine in the state of New York or in any other jurisdiction where that practice is dependent on a valid New York state license to practice medicine.

> Any practice of medicine in the state of New York or in any other jurisdiction where that practice is dependent on a valid New York state license to practice medicine in violation of this Commissioner's Summary Order shall constitute Professional Misconduct within the meaning of N.Y. Educ. Law §6530 and may constitute unauthorized medical practice, a felony defined by N.Y. Educ. Law §6512.

This Order shall remain in effect until the final conclusion of a hearing that shall commence within thirty (30) days after the final conclusion of the disciplinary proceeding in the state of California. The hearing will be held pursuant to the provisions of NY. Pub. Health Law §230, and N.Y. State Admin. Proc. Act §301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct, on a date and at a location to be set forth in a written Notice of Referral Proceeding, together with a Statement of Charges, to be provided to

Respondent after the final conclusion of the California proceeding. Said written Notice may be provided in person, by mail or by other means. If Respondent wishes to be provided said written notice at an address other than those set forth above, Respondent shall so notify, in writing, both the attorney whose name is set forth on this Order and the Director of the Office of Professional Medical Conduct, at the addresses set forth below.

Respondent shall notify the Director of the Office of Professional Medical Conduct, New York State Department of Health, 433 River Street, Suite 303, Troy, NY 12180-2299 via Certified Mail, Return Receipt Requested, of the final conclusion of the California proceeding, immediately upon such conclusion.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW SECTION 230-A. YOU ARE URGED TO OBTAIN AN ATTORNEY FOR THIS MATTER.

DATE: Albany, New York
March 10, 2005

ANTONIA C. NOVELLO, M.D., M.P.H, Dr. P. H.
Commissioner

Inquires should be addressed to:

Robert Bogan
Associate Counsel
Office of Professional Medical Conduct
433 River Street – Suite 303
Troy, New York 12180
(518) 402-0828

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

DAVID T. THORNTON, Executive Director, Medical Board of California, Department of Consumer Affairs, State of California, Petitioner, v. **JANE ESPEJO NORTON, M.D.** 74-133 El Paseo, Suite 6 Palm Desert, CA 92260 Physician's and Surgeon's Certificate No. G 34784, Respondent.	Case Nos. 09-2003-151957, 09-2003-150692 and 09-2003-155272 **INTERIM ORDER OF SUSPENSION** (Cal. Gov. Code, § 11529.) Date: September 30, 2004 Time: 2:00 p.m. Location: Office of Admin. Hearings 1350 Front Street, Room 6022 San Diego, CA 92101 ALJ: Hon. Steven V. Adler, Presiding

TO JANE ESPEJO NORTON, M.D.:

Having read and considered the Petition for Interim Order, supporting memorandum of points and authorities, declarations and exhibits in support thereof, and any opposition papers filed thereto, in the above-entitled matter;

IT IS HEREBY ORDERED AND ADJUDGED THAT this is a proper case for the issuance of an interim order pursuant to Government Code section 11529, subdivisions (a), in that the declarations and exhibits submitted in support of the petition show that:

1. Respondent has engaged in, or is about to engage in, acts or omissions constituting a violation or violations of the Medical Practice Act; and

2. Permitting respondent to continue to engage in the practice of medicine will endanger the public health, safety, and welfare.

IT IS FURTHER ORDERED AND ADJUDGED THAT this is a proper case for the issuance of an interim order without notice pursuant to Government Code section 11529, subdivisions (b), in that it appears from the facts shown by the declarations and exhibits submitted in support of the petition that serious injury will result to the public before this matter can be heard on notice.

THEREFORE, IT IS HEREBY ORDERED THAT, pending further order from the Office of Administrative Hearings, Physician's and Surgeon's Certificate No. G 34784 which was heretofore issued by the Medical Board of California to respondent Jane Espejo Norton, M.D., is immediately suspended and respondent Jane Espejo Norton, M.D., is immediately prohibited from practicing medicine in the State of California.

IT IS FURTHER ORDERED that respondent Jane Espejo Norton, M.D., shall appear at the Office of Administrative Hearings located at 1350 Front Street, Room 6022, San Diego, California, 92101, on the 14th day of OCTOBER, 2004, at 1:30 p.m., or as soon thereafter as the matter can be heard, then and there to show cause, if any, why this interim order suspending Physician's and Surgeon's Certificate No. G 34784 should not remain in full force and effect pending the issuance of a final decision by the Division of Medical Quality of the Medical Board of California after an administrative hearing on the charges and allegations to be contained in an Accusation to be filed against her in accordance with the requirements of California Government Code section 11529, subdivision (f).

A copy of this interim order, the Petition for Interim Order and supporting memorandum of points and authorities, declarations and exhibits ~~shall be sent to respondent by 24 hour delivery service at the following address: 74-133 El Paseo, Suite 6, Palm Desert, CA 92260.~~ have been provided to respondent's counsel at the hearing on September 30, 2004.

Any response to the Petition for Interim Suspension, supporting memorandum of points and authorities, declarations and exhibits shall be filed by respondent Jane Espejo Norton, M.D., with the Office of Administrative Hearings, and delivered to petitioner's attorney of

record, Thomas S. Lazar, Deputy Attorney General, not ~~less~~ later than October 12, 2004, at ~~12 noon~~ 12 noon. ~~days before the date set for hearing on the interim suspension order~~.

Any reply to the response filed by respondent may be submitted by petitioner in writing at the hearing on the interim suspension order or presented orally at the hearing itself.

IT IS SO ORDERED this 30th day of September, 2004.

HONORABLE STEVEN V. ADLER
PRESIDING ADMINISTRATIVE LAW JUDGE

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

DAVID T. THORNTON, Executive Director, Medical Board of California, Department of Consumer Affairs, State of California, Petitioner, v. JANE ESPEJO NORTON, M.D. 74-133 El Paseo, Suite 6 Palm Desert, CA 92260 Physician's and Surgeon's Certificate No. G 34784, Respondent.	Case No. 09-2003-151957 OAH Case No. L2004090595

INTERIM ORDER OF SUSPENSION
(Gov. Code § 11529)

On October 27, 2004, in San Diego, California, Greer D. Knopf, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter.

Thomas S. Lazar, Deputy Attorney General, represented petitioner David T. Thornton, Executive Director of the Medical Board of California, Department of Consumer Affairs, State of California.

Jay N. Hartz, Hooper Lundy & Bookman, Inc., attorney at law, appeared and represented respondent Jane Espejo Norton, M.D. who was also present at the hearing.

Evidence was taken and argument was presented by the parties. The record was closed and the matter was submitted on October 27, 2004.

FACTUAL FINDINGS

1. Petitioner David T. Thornton (hereinafter petitioner) is the Executive Director of the Medical Board of California (hereinafter referred to as "the Board"), and brought this action in his official capacity.

2. On July 1, 1977, the Board issued a license, Physician's and Surgeon's Certificate No. G 34784 (hereinafter the license) to respondent Jane Espejo Norton, M.D. (hereinafter respondent). The license was in full force and effect, except as noted herein, at all times relevant to this case and will expire on January 31, 2005, unless renewed.

3. On September 30, 2004, petitioner filed a Petition for Interim Order of Suspension (hereinafter ISO petition) against respondent dated September 30, 2004. On September 30, 2004, Presiding Administrative Law Judge Steven V. Adler issued an Interim Order of Suspension (hereinafter ISO) suspending respondent's license. The hearing on the ISO was set for October 27, 2004 and the proceeding herein followed.

4. On October 27, 2004, the hearing on the ISO was conducted. The administrative court has read and considered all documents properly submitted by the parties and received into evidence. The following facts are established.

5. In August 1995, respondent's license was previously disciplined by the Board. On August 9, 1995, in case no. 06-90-2489, the Board issued a Decision, effective September 4, 1998, suspending respondent's medical license for one year, stayed, and respondent was put on probation for five years subject to terms and conditions. The terms and conditions of probation included: (1) A limitation on respondent's surgical privileges such that she was prohibited from performing major reduction mammoplasties and major abdominoplasties without prior approval from an assigned monitor; (2) a monitoring of her medical practice; (3) limiting respondent to two office locations; and (4) requiring respondent to submit a plan of practice regarding coverage physicians and hospitalization of patients to the Board for its prior approval.

On August 6, 1998, the board issued a Decision granting respondent's Petition for Penalty Relief to terminate her probation early. The effective date of this decision was stayed until respondent demonstrated to the satisfaction of the Board that she had obtained a valid California driver's license. Respondent obtained the driver's license almost a year later and the Board terminated her probation on July 22, 1999.

6. On June 2, 2004, in a case entitled *United States of America v. Jane Norton*, in the United States District Court for the Southern District of New York, respondent pleaded guilty to and was convicted of two counts of violating Title 18, United States Code, sections 1003 and 1002. Count one included charges that respondent submitted to the United States Small Business Administration a fraudulent loan application seeking disaster business loans that contained false statements concerning damage to her medical practice equipment being

caused by Hurricane Floyd. Count two included charges that respondent submitted to the United States Federal Emergency Management Agency a fraudulent request to obtain a larger grant for emergency home repair assistance that falsely claimed a piece of her medical equipment had been destroyed in Hurricane Floyd.

These criminal convictions involved moral turpitude and are substantially related to the qualifications, functions, and duties of a physician and surgeon. They constitute conduct that breaches the rules and ethical conduct expected of the medical profession and further is conduct that is unbecoming a member in good standing of the medical profession and demonstrates an unfitness to practice medicine.

The District Court sentenced respondent for these crimes on September 28, 2004. The court sentenced respondent to two years probation with 30 days of home detention, a $5,000.00 fine and alcohol aftercare treatment at the discretion of the probation officer.

7. In July 2003, respondent was in practice as a non-board certified plastic surgeon in Palm Desert, California. Patient LB (hereinafter LB) came to see respondent seeking elective plastic surgery. LB was not a suitable candidate for elective plastic surgery. LB presented herself as a 56-year-old woman with multiple medical problems. LB suffered with systemic lupus. She had a diagnosis of mixed connective tissue disease, chronic bipolarism, fibromyalgia and osteoarthritis of the knees. She also had been a heavy smoker for many years, smoking from one to three packs a day. LB clearly had psychiatric conditions as she was taking psycho-tropic medications at the time of her initial consultation with respondent. During LB's first consultation with respondent, respondent agreed to perform surgery on LB even though LB was not healthy enough to undergo such surgery and respondent had not even performed any physical examination on her.

In addition, respondent agreed to perform surgery on LB before consulting with LB's treating rheumatologist, Dr. Howard N. Kaye. When respondent did consult Dr. Kaye, he did not give approval for the surgery on LB. In fact, he recommended that LB not have any plastic surgery and did not approve of or give his permission for respondent to perform plastic surgery on LB. Dr. Kaye had already refused to approve plastic surgery for LB two years before when LB had consulted plastic surgeon Carroll Bucko, M.D. At that time, Dr. Kaye advised Dr. Bucko that lupus patients do not heal well from plastic surgery and Dr. Bucko declined to perform the surgery. Respondent maintains Dr. Kaye gave his approval for the surgery when she spoke to him, but this assertion is outweighed by the overwhelming and more credible evidence to the contrary.

8. Despite the clear medical and psychiatric contraindications for LB to undergo plastic surgery and despite the recommendation against such surgery from LB's treating physician, respondent undertook a series of plastic surgeries on LB. From July 19, 2003 to September 9, 2003, respondent performed five cosmetic surgeries on LB. The first surgery performed on July 19, 2003 was a liposuction procedure. The second surgery took place just two and one-half weeks later on August 5, 2003, and was a breast reduction surgery. This second surgery was planned to take three hours and instead it took eight hours. After the

second surgery, LB did not heal properly and the breast nipple ultimately became necrotic and died. Even though LB's breasts were not healing, respondent went forward with yet another surgery on LB. The third surgery took place just 11 days after the second surgery on August 16, 2003. The third surgery was an abdominal liposuction and a "tummy tuck" procedure. The fourth surgery was performed 14 days later on August 30, 2003 to remove necrotic tissue from LB's breasts and to remove the necrotic nipple from LB's left breast. Thereafter, LB still had open wounds from the prior surgeries, but just ten days later on September 9, 2003, respondent performed a fifth surgery on LB. This surgery was another liposuction procedure. Respondent performed five prolonged elective plastic surgeries on an obviously unhealthy patient over the course of just eight weeks. Respondent charged LB a total of $275,000.00 for these surgeries.

LB did not heal well after any of these surgeries and ultimately she had to be hospitalized for an extended period of time. On September 15, 2003, LB went to the emergency room in respiratory distress and was admitted into the ICU for treatment. LB remained hospitalized for approximately one month. Subsequently, on July 25, 2004, nearly one year later, L.B. passed away, apparently from conditions unrelated to these surgeries.

9. Respondent appears to have been repeatedly untruthful and dishonest with respect to this patient and this case. Respondent reported in the operative report for the third surgery on LB that Dr. Kaye approved the surgery. This was not true. Then in September, respondent reported in the operative report for the fifth surgery on LB that Dr. Kaye had approved that surgery. This was also not true. Dr. Kay had not authorized or approved any cosmetic surgery for LB. In addition, respondent claimed she had appropriate physician coverage for her patients when she left town following LB's last surgery. Respondent identified Dr. Mary Howell as her admitting physician and Dr. William Canada as her coverage when she was gone. Yet, Dr. Howell states she has never met respondent and has no recollection of making an agreement with respondent to serve as admitting physician for respondent's patients. Respondent has submitted a letter from April 2001 from Dr. Howell that confirms Dr. Howell agreed to admit and follow respondent's patients. Dr. Howell admits she may have spoken to respondent back in 1998, but has never been the admitting physician for any of respondent's patients. With respect to Dr. Canada, respondent told the Board investigator that Dr. Canada works with respondent and shares an office with her when in fact Dr. Canada practices and maintains his office in Las Vegas, Nevada.

10. Respondent has submitted her own declaration that seeks to refute much of the allegations against her. However, respondent has demonstrated a willingness to falsify information regarding her practice and her patient. Respondent clearly falsified information she submitted to the federal government that became the subject of her federal criminal conviction. Respondent also seems to have falsified information she gave to the Board investigator in this matter. Many of respondent's assertions set forth in her declaration are disputed by declarations of disinterested parties. This administrative court finds respondent to lack credibility. This is in light of respondent's criminal convictions for submitting fraudulent documentation and in light of the persuasive and credible evidence in the record that contradicts many facts that respondent asserts in her declaration.

11. As opposition to the petition for an ISO, respondent has submitted the opinion of Dr. Leo A. Gordon, who is board certified by the American Board of Surgery. Dr. Gordon is a surgeon, but not a board certified plastic surgeon. Dr. Gordon opines that respondent was not responsible for the subsequent complications LB developed after she was hospitalized and that respondent was not directly responsible for the conditions that resulted in LB's hospitalization. Dr. Gordon further opines that LB's death was not caused by respondent's surgeries. Dr. Gordon expresses no opinion as to whether respondent presents a threat to the public health, safety, and welfare.

Respondent also submitted a declaration from Dr. Ivor Green. Dr. Green is the anesthesiologist who provided anesthesia services to LB during the surgeries performed by respondent. Dr. Green indicates the surgeries respondent performed on LB were "essentially uneventful." Dr. Green further states he is not aware of any facts that would lead him to conclude respondent is a danger to the public if permitted to continue performing surgery. However, Dr. Green is not a surgeon and he does not state affirmatively that respondent is safe to continue practicing medicine and performing surgeries.

12. Dr. Aaron Stone, who is board certified by the American Board of Surgery and by the American Board of Plastic Surgery, reviewed this case for the Board and submitted a declaration in support of the petition for an ISO. Dr. Stone is a cosmetic and reconstructive plastic surgeon. He reported to the Board regarding his extensive review of the many reports and medical records concerning respondent's treatment of LB. Dr. Stone concludes that respondent has committed multiple acts of gross negligence and unprofessional conduct in her care and treatment of LB. Dr. Stone further opines that to allow respondent to continue to practice medicine will present an extreme risk of serious injury to the public health, safety, and welfare. Dr. Stone's opinion is accepted as the more persuasive opinion herein due to his extensive credentials, his expertise in the specific area of plastic surgery and his direct and unequivocal statements regarding the issue of whether respondent poses a danger to the public.

LEGAL CONCLUSIONS

All conclusions are based on Factual Findings 1-12.

1. There is a reasonable probability that petitioner will prevail in the underlying action.

2. The likelihood of injury to the public in not issuing the order outweighs the likelihood of injury to the licensee in issuing the order.

3. There is sufficient evidence to establish that respondent has engaged in acts or omissions constituting violations of the Medical Practice Act, and permitting respondent to

continue to engage in the practice of medicine will endanger the public health, safety, and welfare.

4. There is sufficient evidence to show that respondent cannot practice medicine without an unacceptable risk of harm to the public and to her patients.

5. Except as otherwise set forth in this Interim Order of Suspension, any and all remaining claims and defenses asserted in this matter are determined not to be established by sufficient evidence or law.

ORDER

Physician's and Surgeon's Certificate No. G 34784, issued to respondent Jane Espejo Norton, is hereby SUSPENDED.

DATED: 11/10/04

GREER D. KNOPF
Administrative Law Judge
Office of Administrative Hearings