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

In the Matter of the Accusation
Against:

FRANK A. SHALLENBERGER, M.D.
1524 Highway 395
P.O. Box 69
Gardnerville, Nevada 89423

Physician's and Surgeon's
License No. G27254

Respondent.

Case No. 12-91-8391

ACCUSATION

Complainant Dixon Arnett, as causes for disciplinary
action, alleges:

PARTIES

1. Complainant is the Executive Director of the
Medical Board of California ("Board") and makes and files this
accusation solely in his official capacity.

LICENSE STATUS

2. On or about July 15, 1974, Physician's and
Surgeon's License No. G27254 was issued by the Board to Frank A.
Shallenberger, M.D. ("respondent"), and at all times relevant
herein, said Physician's and Surgeon's License was in full force and effect. Respondent was also issued a physician's assistant license number SA 14653 which has been in delinquent status since May 31, 1986.

STATUTES

3. This accusation is made in reference to the following statutes of the California Business and Professions Code ("Code"): 

A. Section 2220 provides, in pertinent part, that the Division of Medical Quality may take action against all persons guilty of violating the provisions of Chapter 5 of Division 2 of that Code.

B. Section 2227 provides that the Board may revoke, suspend for a period not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act.

C. Section 2234 provides that unprofessional conduct includes, but is not limited to, the following:

"(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."

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2.
D. Section 725 provides that repeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct.

E. Section 810 provides it shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his professional activities:

   (1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.

   (2) Knowingly prepare, make, or subscribe any writing, with intent to present or use the same, or to allow it to be presented or used in support of any such claim.

F. Section 2251 provides that knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

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3.
DRUGS

4. Heparin, Ventolin Inhaler, Thyroid, and Injectable forms of Aminophylline, Magnesium, B12/Folic Acid, Thymus Extract, EDTA, Vitamin B Complex, Magnesium Chloride, Hydroxocobalamin, Pyridoxine Hydrochloride, and Dexpanthenol, are dangerous drugs as defined in section 4211 of the code.

CHARGES AND ALLEGATIONS

5. RE Patient Nancy P.:

A. Nancy P., then 41 years of age, first saw respondent, who then practiced as a physician and surgeon, in or about Pleasant Hill, California, on September 16, 1988. She reported a family history of asthma and that she reacted with bronchoconstriction to sulfites.

B. Nancy P. saw respondent again on August 15, 1990, for breathing problems. The diagnosis was asthma. The treatment prescribed by respondent included an ozone generator, bowel detoxification, weekly vitamin B and magnesium, and a Ventolin Inhaler. There is no documentation of an examination of the lungs, consideration of a chest X-ray, or spirometry. In a letter to the Medical Board date April 12, 1991, concerning this treatment, respondent stated that he "instituted treatment designed to help her liver with xenobiotic detoxification."

C. The next chart note is dated August 20, 1990 and states only "B6 1cc mag 2cc."

1. Full names of patients will be provided upon a proper request for discovery.
D. On September 12, 1990, respondent notes that the
patient was "still having severe bronchoconstriction around
2 to 4 AM." Again, no physical examination is documented.
The patient received 4cc's of aminophylline and 4 cc's of
normal saline by fast push. The billing document indicates
that there was an "IV by MD." In addition, she received
additional injections of magnesium, B-6 and glycerine.
Respondent suggested the patient may need "yeast protocol."
He also recommended that she might benefit from being in
Mendocino and away from her job as a beauty operator.

E. Nancy P. received IV therapy on September 17, 1990
that was identical to the treatment of September 12, 1990.

F. Nancy P. was next seen on September 20, 1990. The
chart notes state "doing better when gets IV's." Identical
IV preparations were administered. There is no
documentation of any physical examination.

G. On September 21, 1990, Nancy P. again received
aminophylline 4 cc's with sodium chloride by "IV fast push."
Additional IV treatments were given on September 24, 1990,
September 25, 1990, September 26, 1990, September 27, 1990,
September 28, 1990 and October 1, 1990, all of the same
preparations.

H. On September 28, 1990 she was referred to an
acupuncturist. On that occasion her lungs "were checked at
the front desk using the stethoscope."

I. On or about October 1, 1990, respondent left his
practice in the hands of Peter H.C. Mutke, M.D.
J. On October 3, 1990, the patient called respondent at home fearful that she "had contracted pneumonia." He prescribed erythromycin over the phone, according to the patient, and she was also told, according to the patient, that she should begin hydrogen peroxide therapy intravenously.

K. Apparently Nancy P. went to see Dr. Mutke after speaking to respondent. There is a chart note dated October 3, 1990, signed by Dr. Mutke indicating he was aware of the patient's diagnosis of bronchial asthma. There is no notation of a physical examination.

L. Nancy P. states that the evening of October 17, 1990 was particularly difficult for her and that she was unable to sleep because of difficulty breathing. She went to see Dr. Mutke on October 18, 1990, and was administered the same medications that she had received on October 5, 1990, including intravenous hydrogen peroxide.

M. Upon completion of the intravenous therapy, Dr. Mutke told her to "do whatever you think is right" in response to her complaint that she wasn't any better. She then contacted an acupuncturist who eventually, after acupuncture and tea, advised her to go to an emergency room.

N. Nancy P. reported to San Ramon Medical Center Emergency Room where she was seen by Bruce Wafen, M.D. His notes indicate that she had marked expiratory wheezing and an oxygen saturation of 89 per cent. She was subsequently admitted to the hospital for eight days and received
intravenous steroids, standard bronchodilator therapy
including ipratobium, metaproterenol, and systemic steroids.

6. Respondent committed the following acts or
omissions in his treatment of Nancy P.:

(A) Respondent treated Nancy P. without having or
employing the requisite knowledge of asthma pathophysiology,
recognition, management, treatment and care;

(B) Respondent improperly or excessively used "perfect
7" (intestinal cleanser), superoxide dismutase, and/or
vitamin therapy;

(C) Respondent use of Ventolin inhaler for the
patient's asthmatic condition was incomplete therapy;

(D) Respondent failed to perform an adequate physical
examination(s) and/or include physical examination findings
in the office notes;

(E) Respondent failed to perform and/or document the
results of any lung examination performed;

(F) Respondent incorrectly suggested that "spirometry"
would indicate whether or not chemicals at the patient's
work were clearly causing her asthmatic condition;

(G) Respondent suggested that the patient use
"ionizers" to "help clear the air" at the patient's work
environment;

(H) Respondent improperly employed the use of bowel
detoxification, and relied on B6, and ozone generators for
treatment of the patient's asthmatic condition;

(I) Respondent failed to recognize the patient's
setbacks and worsening condition;

(J) Respondent improperly prescribed and/or administered IV hydrogen peroxide in the office;

(K) Respondent administered IV magnesium infusion in his office without proper or any cardiac monitoring;

(L) Respondent improperly and/or without proper medical indication used aminophylline IV (100 mg) via IV push;

(M) Respondent’s use of bowel detoxification, and reliance on B6, and ozone generators, did not provide the patient with appropriate treatment for her asthmatic condition;

(N) Respondent prescribed and/or administered pyridoxine, glycyron, vitamin A, zinc, probioplex, hepasil capsules, "BHI" homeopathic asthma tablets, and viburnum lantana tablets improperly and/or without medical indication;

(O) Respondent continued to use "imagery" and "visualization" as primary treatment modalities despite Nancy P.'s persistent symptoms;

(P) Respondent abandoned Nancy P. and/or transferred her care to another practitioner without adequate notice and consent; and/or

(Q) Respondent’s treatment of Nancy P. was not consistent with the standard of care, was not clinically indicated by either the history, symptoms, physical findings, or laboratory tests, and was potentially
FIRST CAUSES FOR DISCIPLINARY ACTION

7. Respondent is subject to disciplinary action pursuant to section 2234(b) of the Business and Professions Code because he was grossly negligent in the practice of his profession as more particularly described in paragraphs 5 and 6 above.

8. Respondent is further subject to disciplinary action pursuant to section 2234(c) of the Business and Professions Code because he committed repeated negligent acts in the practice of his profession as more particularly described in paragraphs 5 and 6.

9. Respondent is further subject to disciplinary action pursuant to section 2234(d) of the Business and Professions Code because he displayed incompetence in the practice of his profession as more particularly described in paragraphs 5 and 6 above.

10. Respondent is further subject to disciplinary action pursuant to Business and Professions Code section 725 because he committed repeated acts of clearly excessive prescribing and treatments in the practice of his profession, as more particularly described in paragraphs 5 and 6 above.

11. RE Patient Pauline U.: A. On or about October 5, 1989, patient Pauline U., approximately 75 years of age, first saw respondent, who then practiced as a physician and surgeon, in or about Pleasant Hill, California. At that time, she complained of
being "stressed out" because her husband had been
experiencing cerebral vascular accidents (strokes) and was
in a nursing home.

B. Pauline U. had problems sleeping and had gone to
Kaiser where she was treated with Diltiazem, 60 mg., t.i.d.,
and Isosorbide, 20 mg. t.i.d. for angina. She was also
taking Tagamet and had an elevated cholesterol level. She
complained of leg cramps and that she was sleepy during the
day.

C. The physical examination was not remarkable and
respondent's noted plan was to have the patient abstain from
coffee, take Vitamin E twice a day, and have an intravenous
injection (IV) every week of apparently vitamins although
the exact contents of the IV are not stated in the chart
note. With every second IV, the patient was to stop taking
the Isosorbide. He also prescribed numerous vitamins,
magnesium, calcium, and two years of Heparin after the IV's.
Respondent also administered 2 cc.'s of folic acid
intramuscularly (IM).

D. Pauline U. received IV injections on October 5,
1989, October 24, 1989, October 31, 1989, and November 14,
1989. On November 28, 1989, her blood pressure was 142/90.
She was complaining of constant chest pressure for the last
24 hours. Respondent documented that he felt it was
probably angina. An EKG was claimed to show a right bundle
branch block. Respondent administered IV injections and
Nitroglycerin and she was said to feel 100% better, however,
she was transferred to the Kaiser Martinez Emergency Room. It was determined that Pauline U. did not have angina.

E. On or about December 28, 1989, Pauline U. described stress in her life. Respondent gave her thyroid medication, prescribed vitamins and recommended IV injections bi-weekly consisting of vitamins and magnesium. She received similar IV injection treatments on January 26, 1990, March 28, 1990, April 4, April 10, April 16 and April 24, 1990.

12. Respondent committed the following acts or omissions in his treatment of Pauline U.:

   (A) Respondent improperly administered intravenous magnesium and/or failed to indicate the reasons for said use with this patient;

   (B) Respondent failed to timely administer nitroglycerin to abate the patient's myocardial ischemic episode;

   (C) Respondent failed to obtain and/or document the obtaining of informed consent from patient Pauline U. for the intravenous magnesium infusion;

   (D) Respondent administered magnesium infusion in an office setting rather than in a controlled hospital setting;

   (E) Respondent failed to document why magnesium infusion was administered in an office setting rather than in a controlled hospital setting;

   (F) Respondent failed to document the concentration of intravenous magnesium in the patient's medical record;

   (G) Respondent failed to document the dose and route
of administration of nitroglycerin in the patient's medical
record;

(H) Respondent improperly administered vitamin B12,
folic acid, and other vitamins to patient Pauline U. during
her acute chest pain episode;

(I) Respondent failed to perform and/or document
whether there was any careful chemical and clinical
monitoring of blood pressure, heart rate, ECG, and
neurologic signs during the infusion of intravenous
magnesium while the patient was having acute chest pain;

(J) Respondent failed to immediately or timely
transfer patient Pauline U. to the hospital for emergency
cardiac care for immediate evaluation, monitoring and
treatment;

(K) Respondent improperly performed or failed to
document in the patient's medical records why certain
unconventional therapies were administered to patient
Pauline U.;

(L) Respondent improperly prescribed thyroid
medications without proper medical indication; and/or

(M) Respondent's treatment of Pauline U. was not
consistent with the standard of care, was not clinically
indicated by either the history, symptoms, physical
findings, or laboratory tests, and was potentially
detrimental.

SECOND CAUSES FOR DISCIPLINARY ACTION

13. Respondent is subject to disciplinary action
pursuant to section 2234(b) of the Business and Professions Code because he was grossly negligent in the practice of his profession as more particularly described in paragraphs 11 and 12 above.

14. Respondent is further subject to disciplinary action pursuant to section 2234(c) of the Business and Professions Code because he committed repeated negligent acts in the practice of his profession as more particularly described in paragraphs 11 and 12 above.

15. Respondent is further subject to disciplinary action pursuant to section 2234(d) of the Business and Professions Code because he displayed incompetence in the practice of his profession as more particularly described in paragraphs 11 and 12 above.

16. Respondent is further subject to disciplinary action pursuant to Business and Professions Code section 725 because he committed repeated acts of clearly excessive prescribing and treatments in the practice of his profession, as more particularly described in paragraphs 11 and 12 above.

17. **RE Patient Melanie Z.:**

A. On or about June 28, 1991, the Medical Director of CIGNA Health Plan in Oakland filed a complaint with the Medical Board concerning respondent's treatment of patient Melanie Z.

B. Melanie Z. had a mammography examination in 1990 which revealed extensive micro calcification of the right breast.
C. On November 1, 1990, a needle biopsy revealed extensive ductal carcinoma in situ with both comedo and in situ pattern noted as well as central necrosis with calcification.

D. On November 5, 1990, Melanie Z. underwent a right modified radical mastectomy with immediate right breast reconstruction by L. C., M.D.

E. On November 27, 1990, Melanie Z., then 35 years of age, sought treatment from respondent, who then practiced as a physician and surgeon, in or about Pleasant Hill, California. His entire first chart entry is four lines indicating that she had a right mastectomy, that she was being evaluated for chemotherapy, she felt good, wound was healing well and the plan was to "consult post information."

F. On December 27, 1990, Melanie Z. began treatments with respondent that included daily (Monday through Friday) thymus extract therapy.

G. On January 22, 1991, Melanie Z. began receiving rectal insufflation therapy with a half liter of ozone alternating with thymus extract therapy pursuant to an unapproved research study being conducted by respondent. Respondent referred to this study as being approved by the Federal Drug Administration which was not true.

H. On or about February 25, 1991, Melanie Z. began receiving B12 injections as well as folic acid injections alternating with thymus extract and B12 injections. Initially these were given every other day to every third
day.

I. On March 13, 1991, the patient began therapy with manganese subcutaneously, initially given every four days, then weekly. This again was all given concurrently or alternating with thymus extract and B12/folic acid injections. This type of treatment continued until approximately May 15, 1991.

J. Respondent billed Melanie Z.'s insurance company for "chemotherapy."

18. Respondent committed the following acts or omissions in the treatment of Melanie Z.:

(A) Respondent prescribed a method of treatment for Melanie Z. under the guise of an investigational research study, without following appropriate scientific procedures and protocols;

(B) Respondent failed to perform a thorough history and/or physical examination in respondent's initial and subsequent evaluations of Melanie Z;

(C) Respondent's characterization of his treatment of Melanie Z. as being "FDA approved" was false;

(D) Respondent failed to obtain an investigational new drug application for the use of ozone and hydrogen peroxide treatment as per his clinical research study;

(E) Respondent performed unsanctioned medical research without gaining FDA and or Institutional Review Board approval, and/or without obtaining from Melanie Z. proper and true and accurate informed consent;
(F) Respondent prescribed medications and/or treatments to Melanie Z. that were not adequately tested for either safety or efficacy;

(G) Respondent's treatment of Melanie Z. had no proven value; and/or

(H) Respondent's treatment of Melanie Z. was not consistent with the standard of care, was not clinically indicated by either the history, symptoms, physical findings, or laboratory tests, and was potentially detrimental.

THIRD CAUSES FOR DISCIPLINARY ACTION

19. Respondent is subject to disciplinary action pursuant to section 2234(b) of the Business and Professions Code because he was grossly negligent in the practice of his profession as more particularly described in paragraphs 17 and 18 above.

20. Respondent is further subject to disciplinary action pursuant to section 2234(c) of the Business and Professions Code because he committed repeated negligent acts in the practice of his profession as more particularly described in paragraphs 17 and 18 above.

21. Respondent is further subject to disciplinary action pursuant to section 2234(d) of the Business and Professions Code because he displayed incompetence in the practice of his profession as more particularly described in paragraphs 17 and 18 above.

22. Respondent is further subject to disciplinary
action pursuant to Business and Professions Code section 725 because he committed repeated acts of clearly excessive prescribing and treatments in the practice of his profession, as more particularly described in paragraphs 17 and 18 above.

23. Respondent is further subject to disciplinary action pursuant to Business and Professions Code section 810 in that he knowingly presented or caused to be presented a false or fraudulent claim for the payment of a loss under a contract of insurance, and or he knowingly prepared, made, or subscribed a writing, with intent to present or use the same, or to allow it to be presented or used in support of any such claim, as more particularly described in paragraphs 17 and 18 above.

24. Respondent is further subject to disciplinary action pursuant to Business and Professions Code section 2261 in that he knowingly made or signed a document(s) directly or indirectly related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts, in the practice of his profession as more particularly described in paragraphs 17 and 18 above.

25. Respondent is further subject to disciplinary action under Business and Professions Code section 2234 (e) in that he has committed an act or acts involving dishonesty or corruption which are substantially related to the qualifications, functions, or duties of a physician and surgeon, as more particularly described in paragraphs 17 and 18 above.

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26. **RE Patient Willard B.**

   A. Willard B. was a seventy year old male with a history of hypertension, memory loss, and paranoid behavior. The memory loss and paranoia were slowly progressive over the last five years of his life. (He died in December of 1991.) He was diagnosed with Alzheimer's dementia by his Kaiser Permanente physicians.

   B. The first entry in respondent's medical chart concerning his patient Willard B. is dated September 6, 1991. This entry occurred after respondent relocated his practice to Minden, Nevada. It consists of a handwritten order for a series of twenty intravenous infusions to be administered bi-weekly. The infusions were to consist of EDTA, vitamin B complex, magnesium chloride, potassium chloride, hydroxocobalamin, pyridoxine hydrochloride, dextranethenol, ascorbic acid, trace minerals, calcium, and selenium. In addition to these twenty intravenous infusions, a cocktail containing vitamin B complex, magnesium chloride, hydroxocobalamin, pyridoxine hydrochloride, dextranethenol, and distilled water was to be injected IV push over a seven to ten minute interval. Also included in respondent's handwritten orders were laboratory evaluation of hair, blood and urine, which were to be collected at specified times before and during the infusions. These handwritten orders were faxed to Willard B.'s son, in fremont, California, where a registered nurse administered the treatments ordered by respondent. It was
not indicated in the chart who was to administer the
infusions.

C. Respondent's orders for intravenous infusions
predated his first and only face to face contact with
Willard B. by four days. An office visit dated September
10, 1991, in Nevada, included a physical examination of the
fundis, carotids, heart, abdomen, prostate, legs, pulses, and
blood pressure. No history was included in the note. There
was no formal mental status or neurological examination.
Respondent's impression was "small vessel sclerosis with
senile dementia and depression." His plan included the
previously mentioned infusions, oxygen with exercise, and
tyrosine. Mention was also made of hydergine.

D. Absent from the medical chart are the results of
the blood work, hair analysis, and urinalysis that he
ordered. There is no record of how many infusions Willard
B. actually received, who administered them, or where they
were to be administered. There are no follow-up plans.

27. Respondent committed the following acts or
omissions in the treatment of Willard B.: 

(A) Respondent prescribed nonemergent, intravenous
therapy to a patient he had never seen;

(B) Respondent prescribed protracted intravenous
infusions of vitamins, minerals, and chelators to a patient
with Alzheimer's Dementia;

(C) Respondent did not attempt to contact Willard B.'s
Kaiser physicians, and/or other physicians, and/or obtain

19.
his prior medical records, and/or to perform the appropriate
dworkup himself in order to verify a reversible cause of
dementia and/or to take or record a medical history, and/or
to perform or record a mental status or neurological
examination;

(D) Respondent prescribed medication and treatment to

a patient he had never seen or communicated with directly;

(E) Respondent failed to provide follow-up care;

(F) Respondent failed to arrange additional face to

face evaluations;

(G) Respondent failed to communicate with the

health care provider administering the infusions;

(H) Respondent failed to obtain laboratory monitoring

of Willard B.'s condition; and/or

(I) Respondent's treatment of Willard B. was not

consistent with the standard of care, was not clinically

indicated by either the history, symptoms, physical

findings, or laboratory tests, and was potentially

detrimental.

FOURTH CAUSES FOR DISCIPLINARY ACTION

28. Respondent is subject to disciplinary action

pursuant to section 2234(b) of the Business and Professions Code

because he was grossly negligent in the practice of his

profession as more particularly described in paragraphs 26 and 27

above.

29. Respondent is further subject to disciplinary

action pursuant to section 2234(c) of the Business and
Professions Code because he committed repeated negligent acts in
the practice of his profession as more particularly described in
paragraphs 26 and 27 above.

30. Respondent is further subject to disciplinary
action pursuant to section 2234(d) of the Business and
Professions Code because he displayed incompetence in the
practice of his profession as more particularly described in
paragraphs 26 and 27 above.

31. Respondent is further subject to disciplinary
action pursuant to Business and Professions Code section 725
because he committed repeated acts of clearly excessive
prescribing and treatments in the practice of his profession, as
more particularly described in paragraphs 26 and 27 above.

ADDITIONAL CAUSES FOR DISCIPLINARY ACTION

32. Respondent's conduct as set forth set forth
hereinabove in the First through Fourth Causes For Disciplinary
Action, collectively, or in any combination or permutation
thereof, constitutes general unprofessional conduct and is cause
for disciplinary action pursuant to section 2234 of the Business
and Professions Code.

33. Respondent's conduct as set forth set forth
hereinabove in the First through Fourth Causes For Disciplinary
Action, collectively, or in any combination or permutation
thereof, constitutes gross negligence and is cause for
disciplinary action pursuant to section 2234(b) of the Business
and Professions Code.

34. Respondent's conduct as set forth set forth

21.
hereinabove in the First through Fourth Causes For Disciplinary Action, collectively, or in any combination or permutation thereof, constitutes repeated negligent acts and is cause for disciplinary action pursuant to section 2234(c) of the Business and Professions Code.

35. Respondent’s conduct as set forth set forth hereinabove in the First through Fourth Causes For Disciplinary Action, collectively, or in any combination or permutation thereof, constitutes incompetence and is cause for disciplinary action pursuant to section 2234(d) of the Business and Professions Code.

36. Respondent’s conduct as set forth set forth hereinabove in the First through Fourth Causes For Disciplinary Action, collectively, or in any combination or permutation thereof, constitutes repeated acts of clearly excessive prescribing or administering of drugs or treatment, and/or repeated acts of clearly excessive use of diagnostic or treatment facilities, as determined by the standard of the community of licensees and is cause for disciplinary action pursuant to section 725 of the Business and Professions Code.

INVESTIGATION AND ENFORCEMENT COSTS

37. California Business and Professions Code section 125.3, subdivision (a), provides, in pertinent part, that in any order issued in resolution of a disciplinary proceeding, the board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs
of investigation and enforcement of the case.

PRAYER:

WHEREFORE, complainant requests that the Board hold a hearing on the matters alleged herein, and that following said hearing, the Board issue a decision:

1. Revoking or suspending Physician’s and Surgeon’s License Number G27254, heretofore issued to respondent Frank A. Shallenberger, M.D.; and

2. Ordering respondent to pay a sum not to exceed the reasonable costs of investigation and enforcement of the case; and

3. Taking such other and further action as the Board deems appropriate to protect the public health, safety and welfare.

DATED: May 9, 1994

[Signature]

Dixon Arnett
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

MBC File No. 12 92 17943
12 91 8391
12 91 12030