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

In the Matter of the First Amended Accusation Against: **Kimberley Ellen Fillmore, M.D.** **Physician's & Surgeon's Certificate No G 74184** **Respondent.**	**Case No. 800-2015-018838**

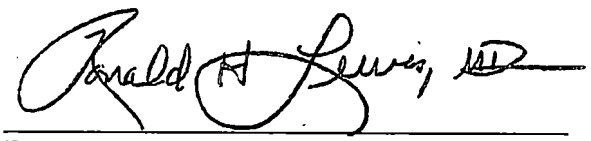
DECISION

The attached Stipulated Settlement for Public Reprimand and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on June 4, 2020.

IT IS SO ORDERED May 5, 2020.

MEDICAL BOARD OF CALIFORNIA



Ronald H. Lewis, M.D., Chair
Panel A

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **KIMBERLEY ELLEN FILLMORE, M.D.** 2864 Sea Bird Way Stockton, CA 95209-4271 Physician's and Surgeon's Certificate No. G74184 Respondent.	Case No. 800-2015-018838 OAH No. 2019120079 **STIPULATED SETTLEMENT FOR PUBLIC REPRIMAND AND DISCIPLINARY ORDER**

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

PARTIES

1. Christine J. Lally (Complainant) is the Interim Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Lynne K. Dombrowski, Deputy Attorney General.

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2. Respondent Kimberley Ellen Fillmore, M.D. (Respondent) is represented in this proceeding by attorney Dominique Pollara, whose address is: Pollara Law Group, 100 Howe Avenue, Suite 165N, Sacramento, CA 95825; tel. 916-550-5880; email: dp@pollara-law.com.

3. On or about June 2, 1992, the Board issued Physician's and Surgeon's Certificate No. G74184 to Kimberley Ellen Fillmore, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2015-018838, and will expire on June 30, 2020, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2015-018838 was filed before the Board and, with all other statutorily required documents, was properly served on Respondent on February 15, 2019, and it is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on September 25, 2017. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of First Amended Accusation No. 800-2015-018838 is attached as Exhibit A and incorporated herein by reference as if fully set forth.

CURRENT DISCIPLINE: PROBATION

6. The Board issued a Decision and Order on October 13, 2016 in a disciplinary action entitled *In the Matter of the Accusation Against Kimberley Ellen Fillmore, M.D.* before the Medical Board of California, Case Number 12-2013-233171. In said Decision and Order, discipline was imposed on Respondent's license whereby a license revocation was stayed and Respondent's license was placed on three years of probation, which became effective on November 10, 2016. That Decision is now final and in effect and it is incorporated herein by reference as if fully set forth. The probation includes the following special terms and conditions: (1) completion of a Medical Record Keeping Course and (2) successful completion of a Clinical Training Program with a Professional Enhancement Program.

7. As set forth in Probation Term No. 12 of the Decision and Order, the period of the probation shall be extended until this matter is final. Accordingly, upon its effective date, the

Disciplinary Order in this matter will supersede the current Decision and Order in effect in Case No. 12-2013-233171.

ADVISEMENT AND WAIVERS

8. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2015-018838. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

11. Respondent understands and agrees that the charges and allegations in First Amended Accusation No. 800-2015-018838, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

12. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the First Amended Accusation, and that Respondent hereby gives up her right to contest those charges.

13. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

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CONTINGENCY

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

15. The parties understand and agree that electronic format, Portable Document Format (PDF), and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

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

DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED that Respondent Kimberley Ellen Fillmore, M.D., Physician's and Surgeon's Certificate No. G74184, shall be and herby is publicly reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This public reprimand, which is issued in connection with Respondent's conduct as set forth in First Amended Accusation No. 800-2015-018838, is as follows:

> You demonstrated unprofessional conduct with regard to the care and treatment of Patients A – E and failed to maintain adequate records for Patients A, B, D, and E, pursuant to Business and Professions Code section 2234, subdivision (c) and section 2266.

B. EDUCATION COURSE.

Within 120 calendar days of the effective date of this Decision, Respondent shall enroll in a review course in Advanced Life Support in Obstetrics (ALSO), approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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ACCEPTANCE

I have carefully read the above Stipulated Settlement for Public Reprimand and Disciplinary Order and have fully discussed it with my attorney, Ms. Dominique Pollara. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement for Public Reprimand and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California. I fully understand that any failure to comply with the terms and conditions of the Disciplinary Order set forth above shall constitute unprofessional conduct and that my Physician's and Surgeon's Certificate will be subject to further disciplinary action.

DATED: 4/9/2020

KIMBERLEY EILEN FILLMORE, M.D.
Respondent

I have read and fully discussed with Respondent Kimberley Ellen Fillmore, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement for Public Reprimand and Disciplinary Order. I approve its form and content.

DATED: 4/10/2020

DOMINIQUE POLLARA
Attorney for Respondent

ENDORSEMENT

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

DATED: 04/13/2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

Lynne K. Dombrowski

LYNNE K. DOMBROWSKI
Deputy Attorney General
Attorneys for Complainant

SF2017203829

Exhibit A

First Amended Accusation No. 800-2015-018838

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

In the Matter of the First Amended Accusation Against: **Kimberley Ellen Fillmore, M.D.** 2864 Sea Bird Way Stockton, CA 95209-4271 Physician's and Surgeon's Certificate No. G74184, Respondent.	Case No. 800-2015-018838 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about June 2, 1992, the Medical Board issued Physician's and Surgeon's Certificate Number G74184 to Kimberley Ellen Fillmore, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2020, unless renewed.

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JURISDICTION

3. This First Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code states:

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

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

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

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

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

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

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

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

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FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence and/or Repeated Negligent Acts and/or Incompetence re: Patient A)

7. Respondent Kimberley Ellen Fillmore, M.D. is subject to disciplinary action for unprofessional conduct through gross negligence and/or repeated negligent acts or omissions and/or incompetence, under Business and Professions Code section 2234, subdivisions (b) and/or (c) and/or (d), with regard to Patient A.[1] The circumstances are presented herein below.

8. On or about August 20, 2015, Respondent counseled Patient A about having a sterilization surgery, a laparoscopic tubal ligation or tubal removal. Both Patient A and Respondent signed the state-mandated PM330 consent form that acknowledged that the patient was informed of the risks and benefits of the procedure.

9. On or about October 25, 2015, Respondent performed and documented a pre-operative history and physical of Patient A. There is inadequate documentation regarding the patient's pulmonary status, her cardiac status, and the details about the patient's prior surgeries. The patient was a 38-year-old morbidly obese female with significant co-morbid conditions: uncontrolled diabetes, hypertension, GERD, hypothyroidism, depression, and a history of bronchitis and pneumonia.

10. On or about October 26, 2015, Respondent performed a laparoscopic tubal ligation of Patient A. Respondent prescribed a prophylactic antibiotic, Ancef, that was administered prior to the procedure. Respondent noted that the surgery lasted two hours longer than the usual surgical time because of technical challenges encountered with scar tissues from previous surgeries and the patient's high BMI. When hematuria was noted toward the end of the procedure, Respondent consulted a urologist. A retrograde cystogram was done and no leakage was noted in the area of the tubal ligation surgery. A Foley catheter was placed and the patient was sent to recovery and later was discharged home. No other surgical consultation occurred during the surgery.

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[1] All patients will be identified by letters, in order to protect their rights to privacy. The identities of the patients will be revealed to Respondent through discovery.

11. Respondent, as the operating physician, signed the physician statement portion of Form PM330 that needed to be completed on the day of the surgery. Respondent, however, did not fully complete the form, as required.

12. Patient A returned to the hospital's emergency room later in the night of October 26, 2015. The patient reported pain that was 8 out of 10. There was some discharge from the incision site. The patient was discharged home several hours later after pain control was reached.

13. On October 31, 2015, Patient A returned to the hospital's emergency department complaining of severe pain, 10 out of 10, with drainage from the surgical sites, diarrhea, general weakness, chills and aches. She was tachycardic despite being afebrile. A CT scan showed a 5.5 cm. abscess in the subcutaneous tissue of the anterior pelvis. The patient was admitted for treatment of the abscess and of sepsis.

14. On or about October 31, 2015, when Respondent visited the patient in the hospital, the patient's mother told her that she no longer wanted Respondent to continue treating her daughter. Respondent left the room and did not see Patient A again.

15. On October 31, 2015, Patient A underwent exploratory surgery and a repair of the enterocutaneous fistula with a small bowel resection and a resection of the infected mesh, which was performed by another surgeon. The patient had sepsis, acute renal insufficiency, hyponatremia, and hemodynamic instability. The patient was intubated and transferred to the ICU post-operatively.

16. On November 4, 2015, Patient A's condition worsened in the ICU and she was returned to the operating room for a suspected anastomotic leak. There was a notable leaking of stool from the sigmoid colon which had not been previously noted during the 10/31/2015 surgery. Patient A underwent a sigmoid resection and diverting loop ileostomy. The patient was returned to the ICU where she stayed an additional three days.

17. On November 14, 2015, Patient A was returned to the operating room due to the ileostomy leak and an ileostomy reversal was done.

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18. Respondent's overall conduct, acts and/or omissions, with regard to Patient A, as set forth in paragraphs 7 through 17 herein, constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or incompetence, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or (c) and/or (d), and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct, jointly and/or severally, as follows:

a. Respondent's pre-operative history and physical of the patient was incomplete, did not adequately document the patient's surgical history, and/or did not document the patient's scars from past surgeries, particularly abdominal scars. Respondent also did not adequately document the discussion of risks and benefits of the elective surgery in light of the substantial risks given the patient's significant medical conditions.

b. The initial operative report lacked important clinical details as well as findings.

c. The PM330 form was not fully completed by Respondent and did not comply with the state-mandated requirements.

d. Respondent failed to obtain an intra-operative evaluation and consultation for evaluation of the surgical sites along the bowel for possible bowel injury after extensive lysis of adhesion.

e. Respondent failed to adequately prepare for the surgery, failing to anticipate possible complications and to consider pre-operative clearance.

f. Respondent demonstrated a lack of knowledge with regard to the potential risks of the surgical technique used and about the failure rate of the tubal ligation procedure.

g. Respondent failed to consider an alternative procedure in light of the patient's medical condition and/or failed to recognize pre-operatively the additional risks of surgery for this patient.

h. Respondent prescribed an unnecessary and unindicated antibiotic for a low-risk procedure.

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SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts and/or Incompetence re: Patient B)

19. Respondent Kimberley Ellen Fillmore, M.D. is subject to disciplinary action for unprofessional conduct through general unprofessional conduct, repeated negligent acts or omissions and/or incompetence, under Business and Professions Code section 2234, subdivisions (c) and/or (d), with regard to Patient B. The circumstances are presented herein below.

20. On or about January 24, 2015, Patient B, a 26-year-old female who was a grava 4, para 2 at 30.6 weeks, presented to the hospital and was admitted for pre-term premature rupture of membranes (PPROM).

21. Patient B presented with a previous obstetrical history and current pregnancy that was complicated including, but not limited to: a pre-viable delivery at 20 weeks; pre-mature deliveries at 28 and at 31 weeks, both of which required cesarean sections; a history of amniotic fluid embolism during the last delivery; gestational diabetes; and morbid obesity.

22. Respondent's treatment of Patient B consisted of IV antibiotics to prolong the latency period, steroids for acceleration of fetal lung maturity, and IV magnesium sulfate for stopping labor. Patient B was also given Heparin.

23. On or about January 26, 2015, Respondent was notified of the request by the patient's family that the patient be transferred to a facility of higher care level. The hospital was designated as a Level 2A NICU facility. Respondent signed a written transfer order that assessed the patient as stable for transfer to a higher care facility about 48 hours after her arrival.

24. Respondent, who had not directly consulted an NICU physician since Patient B's admission, got into a verbal public altercation at the hospital with the NICU physician about consulting with Patient B without Respondent's permission.

25. At the time of the transfer, Respondent had not completed the admission history and physical of the patient.

26. Respondent's overall conduct, acts and/or omissions, with regard to Patient B, as set forth in paragraphs 19 through 25 herein, constitutes unprofessional conduct through repeated negligent acts and/or incompetence, pursuant to Business and Professions Code Sections 2234

subdivisions (c) and/or (d), and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct, jointly and/or severally, as follows:

a. Respondent's history and physical of Patient B was incomplete and lacked critical information pertinent to the patient's care, e.g. vital signs, prior surgical history, fetal assessment, and clinical findings to support a documented treatment plan. Respondent did not complete and document a full history and physical prior to the patient's transfer.

b. Respondent's transfer summary was incomplete.

c. Respondent demonstrated a lack of knowledge regarding the management of prematurity complicating pregnancy.

d. Respondent demonstrated a lack of knowledge regarding the administration of heparin for prevention of amniotic fluid embolism.

e. Respondent acted unprofessionally in engaging in a public verbal altercation with another physician regarding the transfer of care.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts re: Patient C and/or Patient D and/or Patient E)

27. Respondent Kimberley Ellen Fillmore, M.D. is subject to disciplinary action for unprofessional conduct through repeated negligent acts or omissions under Business and Professions Code section 2234, subdivision (c), with regard to Patient C and/or Patient D and/or Patient E. The circumstances are presented herein below.

Patient C

28. On or about September 18, 2015, Respondent treated Patient C with an IV prophylactic antibiotic, Ancef, prior to a scheduled Dilation and Curettage and a routine hysteroscopy procedure. Patient C, a female who was 16 years of age, was prepped for surgery but the procedure was cancelled when Respondent failed to appear.

Patient D

29. On or about October 15, 2015, Respondent performed a routine hysteroscopy and a loop electrical excision procedure (LEEP) biopsy of the cervix on Patient D. Patient D was a

female who was 25 years of age with a diagnosis of cervical dysplasia and irregular bleeding. Prior to the surgical procedure, Patient D was given by IV a prophylactic antibiotic, Ancef. The surgical procedure performed by Respondent on Patient D required suture ligation for bleeding control. Patient D was sent home the same day, after observation in the PACU.

30. On October 15, 2015, about three hours after discharge, Patient D returned to the hospital and presented with rectal bleeding. The patient was taken to the OR by another physician for examination and surgical intervention to control the rectal bleeding. The examination under anesthesia revealed disruption of the rectal mucosa and treatments were rendered. The patient's cervix did not appear to be the source of the bleeding. The patient received two units of packed cells, was hospitalized overnight, and was discharged home on October 16, 2015.

Patient E

31. On or about January 5, 2015, Respondent saw Patient E who complained of "stabbing pain" in her abdomen/pelvic area. The patient reported having experienced pain ever since the placement of Essure contraception coils about three years earlier. An ultrasound done on January 8, 2015 confirmed an Essure coil on the right-side but a left-side Essure coil was not visualized.

32. On or about January 23, 2015, Respondent saw Patient E for a follow-up visit. The patient continued to complain about pelvic pain. An x-ray confirmed the presence of bilateral Essure coils. Respondent noted a discussion with the patient about a laparoscopy to remove the Essure coils and the fallopian tube, and that she informed the patient that there was no guarantee regarding pain relief.

33. On or about March 23, 2015, Patient E had a pre-operative history and physical completed.

34. The planned procedures were a diagnostic laparoscopy, bilateral salpingectomy, and diagnostic hysteroscopy, and removal of the Essure coils. There is no documentation that Patient E was informed of alternative procedures or the risks involved with the specific procedures, other than those on the standard hospital-issued form.

35. On or about March 27, 2015, Patient E was taken to the hospital operating room where Respondent performed surgical procedures that lasted three hours and twenty-four minutes. Respondent's operative note states that she performed an operative laparoscopy with bilateral salpingectomy and dissection of the right cornual region for an imbedded Essure coil, and diagnostic hysteroscopy, and dilation and curettage. Respondent's dictated description of the procedures, however, does not include a hysteroscopy or a dilation and curettage.

36. In her operative note, Respondent also described that the removal of the left-side coil and tube was easy but that the removal on the right-side was difficult because the Essure coil was not in the fallopian tube. Respondent dissected the cornual region, for approximately one extra hour to find the imbedded right Essure coil. Respondent obtained an intra-operative x-ray that showed a 2 cm right-sided radio-dense object. Respondent's operative note, however, does not describe the x-ray procedure and does not detail at what time during the surgery the x-ray was obtained. There was also no documentation that the removed Essure device or devices were checked or measured to confirm that they were complete.

37. In her interview during the Medical Board's investigation, Respondent stated that she performed a hysteroscopy, which required dilation, but that she did not perform a curettage.

38. Respondent's overall conduct, acts and/or omissions, with regard to Patient C and/or Patient D and/or Patient E, as set forth in paragraphs 27 through 37 herein, constitutes unprofessional conduct through repeated negligent acts, pursuant to Business and Professions Code Sections 2234 subdivision (c), and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct, jointly and/or severally, as follows:

a. Respondent prescribed an unnecessary and unindicated antibiotic to Patient C for a low-risk procedure.

b. Respondent prescribed an unnecessary and unindicated antibiotic to Patient D for a low-risk procedure.

c. Respondent's surgical operative note for Patient D was incomplete and failed to include: the endometrial biopsy done during the procedure; details about the fluid and how much

was used for the diagnostic hysteroscopy; the LEEP electrical settings; and, the size of the loop used for the procedure.

d. Respondent's pre-operative history and physical for Patient D was incomplete and did not include the patient's history of rectal bleeding less than one month prior, when the patient was seen in the emergency department.

e. Respondent did not document obtaining informed consent from the patient and having a discussion with Patient E about alternatives to surgery and a discussion of the risks related to those procedures, other than the risk of failing to control or alleviate pain.

f. Respondent's operative note for Patient E was incomplete and inaccurate:

(1) The note incorrectly listed that a dilation and curettage was performed.

(2) There was no documentation that Respondent performed a hysteroscopy, when she performed the hysteroscopy, and whether there were any findings at the time of the hysteroscopy.

(3) There was no detailed documentation about the procedures performed and the rationale for performing them.

(4) There was no information about the intra-operative x-ray, when during the surgery it was obtained, and whether the 2 cm finding was believed to represent an unremoved portion of the Essure device.

(5) Respondent failed to document the steps taken to control the blood loss, what instruments were used for the dissection, and a description of the removed Essure device or devices.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Maintain Adequate Medical Records

(Patients A, B, D, E)

39. Respondent Kimberley Ellen Fillmore, M.D. is subject to disciplinary action for unprofessional under section 2266 for failing to maintain adequate and accurate records for Patient A and/or Patient B and/or Patient D and/or Patient E. Paragraphs 7 through 38 are incorporated herein by reference as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts (Patients A, B, C, D, E)

40. In the alternative, Respondent Kimberley Ellen Fillmore, M.D. is subject to disciplinary action for unprofessional conduct under section 2234(c) for repeated negligent acts with regard to acts and omissions in the treatments of Patient A and/or Patient B and/or Patient C and/or Patient D and/or Patient E. Paragraphs 7 through 38 are incorporated herein by reference as if fully set forth.

DISCIPLINARY CONSIDERATIONS

41. To determine the degree of discipline, if any, to be imposed on Respondent Kimberley Ellen Fillmore, M.D., Complainant alleges that the Board issued a Decision and Order on October 13, 2016 in a disciplinary action entitled *In the Matter of the Accusation Against Kimberley Ellen Fillmore, M.D.* before the Medical Board of California, Case Number 12-2013-233171. In said Decision and Order, discipline was imposed on Respondent's license, a license revocation was stayed, and Respondent's license was placed on a three-year probation, that became effective on November 10, 2016. The probation includes the following special terms and conditions: (1) completion of a Medical Record Keeping Course and (2) successful completion of a Clinical Training Program with a Professional Enhancement Program. That Decision is now final and in effect and it is incorporated herein by reference as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G74184, issued to Kimberley Ellen Fillmore, M.D.;

2. Revoking, suspending or denying approval of Kimberley Ellen Fillmore, M.D.'s authority to supervise physician assistants and advanced practice nurses;

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3. Ordering Kimberley Ellen Fillmore, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: February 15, 2019

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

SF2017203829