

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

1 XAVIER BECERRA  
Attorney General of California  
2 JANE ZACK SIMON  
Supervising Deputy Attorney General  
3 LYNNE K. DOMBROWSKI  
Deputy Attorney General  
4 State Bar No. 128080  
455 Golden Gate Avenue, Suite 11000  
5 San Francisco, CA 94102-7004  
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E-mail: Lynne.Dombrowski@doj.ca.gov  
7 *Attorneys for Complainant*

8  
9 **BEFORE THE**  
**MEDICAL BOARD OF CALIFORNIA**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the First Amended Accusation  
13 Against:

14 **KIMBERLEY ELLEN FILLMORE, M.D.**  
2864 Sea Bird Way  
15 Stockton, CA 95209-4271

16 Physician's and Surgeon's Certificate  
17 No. G74184

18 Respondent.

Case No. 800-2015-018838

OAH No. 2019120079

**STIPULATED SETTLEMENT FOR  
PUBLIC REPRIMAND AND  
DISCIPLINARY ORDER**

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

22 **PARTIES**

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

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

3 **ADVISEMENT AND WAIVERS**

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

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

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

16 **CULPABILITY**

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

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

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

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1. CONTINGENCY

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

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

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

18 DISCIPLINARY ORDER

19 A. PUBLIC REPRIMAND

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

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

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

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

16           Respondent shall submit a certification of successful completion to the Board or its  
17 designee not later than 15 calendar days after successfully completing the course, or not later than  
18 15 calendar days after the effective date of the Decision, whichever is later.

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1 ACCEPTANCE

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

10  
11 DATED: 4/9/2020

Kimberley E. Fillmore M.D.  
12 KIMBERLEY ELLEN FILLMORE, M.D.  
13 Respondent

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

17  
18 DATED: 4/10/2020

Dominique Pollara  
19 DOMINIQUE POLLARA  
20 Attorney for Respondent

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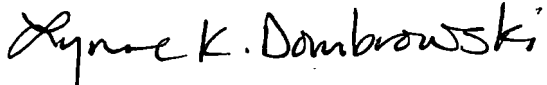
ENDORSEMENT

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  
Deputy Attorney General  
*Attorneys for Complainant*

SF2017203829



**Exhibit A**

**First Amended Accusation No. 800-2015-018838**

1 XAVIER BECERRA  
Attorney General of California  
2 JANE ZACK SIMON  
Supervising Deputy Attorney General  
3 LYNNE K. DOMBROWSKI  
Deputy Attorney General  
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7 *Attorneys for Complainant*

FILED  
STATE OF CALIFORNIA  
MEDICAL BOARD OF CALIFORNIA  
SACRAMENTO *February 15 20 19*  
BY *K. Young* ANALYST

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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:

Case No. 800-2015-018838

**Kimberley Ellen Fillmore, M.D.**  
2864 Sea Bird Way  
Stockton, CA 95209-4271

**FIRST AMENDED ACCUSATION**

Physician's and Surgeon's Certificate  
No. G74184,

Respondent.

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**

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

5       4.     Section 2227 of the Code states:

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

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

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

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

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

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

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

25       5.     Section 2234 of the Code, states:

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

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

3           “(b) Gross negligence.

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

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

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

14           “(d) Incompetence.

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

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

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

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

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

28     ///

1 FIRST CAUSE FOR DISCIPLINE

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

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

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

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

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

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28 <sup>1</sup> 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.

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

4 12. Patient A returned to the hospital's emergency room later in the night of October 26,  
5 2015. The patient reported pain that was 8 out of 10. There was some discharge from the  
6 incision site. The patient was discharged home several hours later after pain control was reached.

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

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

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

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

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

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

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

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

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

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

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

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

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

25 h. Respondent prescribed an unnecessary and unindicated antibiotic for a low-risk  
26 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 gravida 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



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

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

7 b. Respondent's transfer summary was incomplete.

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

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

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

14 **THIRD CAUSE FOR DISCIPLINE**

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

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

21 **Patient C**

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

26 **Patient D**

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

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

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

12 Patient E

13 31. On or about January 5, 2015, Respondent saw Patient E who complained of "stabbing  
14 pain" in her abdomen/pelvic area. The patient reported having experienced pain ever since the  
15 placement of Essure contraception coils about three years earlier. An ultrasound done on January  
16 8, 2015 confirmed an Essure coil on the right-side but a left-side Essure coil was not visualized.

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

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

24 34. The planned procedures were a diagnostic laparoscopy, bilateral salpingectomy, and  
25 diagnostic hysteroscopy, and removal of the Essure coils. There is no documentation that Patient  
26 E was informed of alternative procedures or the risks involved with the specific procedures, other  
27 than those on the standard hospital-issued form.  
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1           35. On or about March 27, 2015, Patient E was taken to the hospital operating room  
2 where Respondent performed surgical procedures that lasted three hours and twenty-four minutes.  
3 Respondent's operative note states that she performed an operative laparoscopy with bilateral  
4 salpingectomy and dissection of the right cornual region for an imbedded Essure coil, and  
5 diagnostic hysteroscopy, and dilation and curettage. Respondent's dictated description of the  
6 procedures, however, does not include a hysteroscopy or a dilation and curettage.

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

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

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

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

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

26           c. Respondent's surgical operative note for Patient D was incomplete and failed to  
27 include: the endometrial biopsy done during the procedure; details about the fluid and how much  
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1 was used for the diagnostic hysteroscopy; the LEEP electrical settings; and, the size of the loop  
2 used for the procedure.

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

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

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

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

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

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

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

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

#### 22 **FOURTH CAUSE FOR DISCIPLINE**

#### 23 **(Unprofessional Conduct: Failure to Maintain Adequate Medical Records**

#### 24 **(Patients A, B, D, E)**

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

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**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