

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

In the Matter of the Accusation Against:

Donald Clyde Willis, M.D.

**Physician's and Surgeon's
Certificate No. G 35712**

Case No. 800-2017-036455

Respondent.

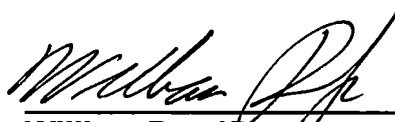
DECISION

The attached Stipulated Surrender of License and 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 November 25, 2020.

IT IS SO ORDERED November 19, 2020.

MEDICAL BOARD OF CALIFORNIA



**William Prasifka
Executive Director**

1 XAVIER BECERRA
Attorney General of California
2 STEVE DIEHL
Supervising Deputy Attorney General
3 MICHAEL C. BRUMMEL
Deputy Attorney General
4 State Bar No. 236116
California Department of Justice
5 2550 Mariposa Mall, Room 5090
Fresno, CA 93721
6 Telephone: (559) 705-2307
Facsimile: (559) 445-5106
7 E-mail: Michael.Brummel@doj.ca.gov
Attorneys for Complainant

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

12 In the Matter of the Accusation Against:

Case No. 800-2017-036455

13 **DONALD CLYDE WILLIS, M.D.**
14 **PO BOX 10818**
15 **San Bernardino, CA 92423-0818**

16 **Physician's and Surgeon's Certificate**
No. G 35712

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

17 Respondent.

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

20 **PARTIES**

21 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
22 California (Board). He brought this action solely in his official capacity and is represented in this
23 matter by Xavier Becerra, Attorney General of the State of California, by Michael C. Brummel,
24 Deputy Attorney General.

25 2. Donald Clyde Willis, M.D. (Respondent) is representing himself in this proceeding
26 and has chosen not to exercise his right to be represented by counsel.

27 3. On or about October 17, 1977, the Board issued Physician's and Surgeon's
28 Certificate No. G 35712 to Donald Clyde Willis, M.D. (Respondent). The Physician's and

1 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in
2 Accusation No. 800-2017-036455 and will expire on June 30, 2021, unless renewed.

3 **JURISDICTION**

4 4. Accusation No. 800-2017-036455 was filed before the Board, and is currently
5 pending against Respondent. The Accusation and all other statutorily required documents were
6 properly served on Respondent on September 9, 2020. Respondent timely filed his Notice of
7 Defense contesting the Accusation. A copy of Accusation No. 800-2017-036455 is attached as
8 Exhibit A and incorporated by reference.

9 **ADVISEMENT AND WAIVERS**

10 5. Respondent has carefully read, and understands the charges and allegations in
11 Accusation No. 800-2017-036455. Respondent also has carefully read, and understands the
12 effects of this Stipulated Surrender of License and Order.

13 6. Respondent is fully aware of his legal rights in this matter, including the right to a
14 hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at
15 his own expense; the right to confront and cross-examine the witnesses against him; the right to
16 present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel
17 the attendance of witnesses and the production of documents; the right to reconsideration and
18 court review of an adverse decision; and all other rights accorded by the California
19 Administrative Procedure Act and other applicable laws.

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

22 **CULPABILITY**

23 8. Respondent admits the truth of each and every charge and allegation in Accusation
24 No. 800-2017-036455, agrees that cause exists for discipline and hereby surrenders his
25 Physician's and Surgeon's Certificate No. G 35712 for the Board's formal acceptance.

26 9. Respondent agrees that if he ever petitions for reinstatement of his Physician's and
27 Surgeon's Certificate No. G 35712, all of the charges and allegations contained in Accusation No.
28 800-2017-036455 shall be deemed true, correct and fully admitted by Respondent for purposes of

1 that reinstatement proceeding or any other licensing proceeding involving respondent in the State
2 of California.

3 10. Respondent understands that by signing this stipulation he enables the Board to issue
4 an order accepting the surrender of his Physician's and Surgeon's Certificate without further
5 process.

6 **CONTINGENCY**

7 11. Business and Professions Code section 2224, subdivision (b), provides, in pertinent
8 part, that the Medical Board "shall delegate to its executive director the authority to adopt a ...
9 stipulation for surrender of a license."

10 12. Respondent understands that, by signing this stipulation, he enables the Executive
11 Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his
12 Physician's and Surgeon's Certificate No. G 35712 without further notice to, or opportunity to be
13 heard by, Respondent.

14 13. This Stipulated Surrender of License and Disciplinary Order shall be subject to the
15 approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated
16 Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his
17 consideration in the above-entitled matter and, further, that the Executive Director shall have a
18 reasonable period of time in which to consider and act on this Stipulated Surrender of License and
19 Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands
20 and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the
21 time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

22 14. The parties agree that this Stipulated Surrender of License and Disciplinary Order
23 shall be null and void and not binding upon the parties unless approved and adopted by the
24 Executive Director on behalf of the Board, except for this paragraph, which shall remain in full
25 force and effect. Respondent fully understands and agrees that in deciding whether or not to
26 approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive
27 Director and/or the Board may receive oral and written communications from its staff and/or the
28 Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the

1 Executive Director, the Board, any member thereof, and/or any other person from future
2 participation in this or any other matter affecting or involving respondent. In the event that the
3 Executive Director on behalf of the Board does not, in his discretion, approve and adopt this
4 Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it
5 shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied
6 upon or introduced in any disciplinary action by either party hereto. Respondent further agrees
7 that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason
8 by the Executive Director on behalf of the Board, Respondent will assert no claim that the
9 Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review,
10 discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or
11 of any matter or matters related hereto.

12 **ADDITIONAL PROVISIONS**

13 15. This Stipulated Surrender of License and Disciplinary Order is intended by the parties
14 herein to be an integrated writing representing the complete, final and exclusive embodiment of
15 the agreements of the parties in the above-entitled matter.

16 16. The parties understand and agree that Portable Document Format (PDF) and facsimile
17 copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures
18 thereto, shall have the same force and effect as the originals.

19 17. In consideration of the foregoing admissions and stipulations, the parties agree the
20 Executive Director of the Board may, without further notice to or opportunity to be heard by
21 Respondent, issue and enter the following Disciplinary Order on behalf of the Board:

22 **ORDER**

23 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 35712, issued
24 to Respondent Donald Clyde Willis, M.D., is surrendered and accepted by the Board.

25 1. The surrender of Respondent's Physician's and Surgeon's Certificate and the
26 acceptance of the surrendered license by the Board shall constitute the imposition of discipline
27 against Respondent. This stipulation constitutes a record of the discipline and shall become a part
28 of Respondent's license history with the Board.

1 2. Respondent shall lose all rights and privileges as a physician and surgeon in
2 California as of the effective date of the Board's Decision and Order.

3 3. Respondent shall cause to be delivered to the Board his pocket license and, if one was
4 issued, his wall certificate on or before the effective date of the Decision and Order.

5 4. If Respondent ever files an application for licensure or a petition for reinstatement in
6 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must
7 comply with all the laws, regulations and procedures for reinstatement of a revoked or
8 surrendered license in effect at the time the petition is filed, and all of the charges and allegations
9 contained in Accusation No. 800-2017-036455 shall be deemed to be true, correct and admitted
10 by Respondent when the Board determines whether to grant or deny the petition.

11 5. If Respondent should ever apply or reapply for a new license or certification, or
12 petition for reinstatement of a license, by any other health care licensing agency in the State of
13 California, all of the charges and allegations contained in Accusation, No. 800-2017-036455 shall
14 be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of
15 Issues or any other proceeding seeking to deny or restrict licensure.

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DATED:

Respondent

DATED:—

Stipulated Surrender of License and Order (Case No. 800-2017-036455)

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ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: _____

DONALD CLYDE WILLIS, M.D.
Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: November 2, 2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General



MICHAEL C. BRUMMEL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-036455

1 XAVIER BECERRA
Attorney General of California
2 STEVE DIEHL
Supervising Deputy Attorney General
3 MICHAEL C. BRUMMEL
Deputy Attorney General
4 State Bar No. 236116
2550 Mariposa Mall, Room 5090
5 Fresno, CA 93721
Telephone: (559) 705-2307
6 Facsimile: (559) 445-5106
E-mail: Michael.Brummel@doj.ca.gov
7 *Attorneys for Complainant*

8
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12 In the Matter of the Accusation Against:

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13 **Donald Clyde Willis, M.D.**
14 **P.O. BOX 10818**
San Bernardino, CA 92423-0818

A C C U S A T I O N

15 **Physician's and Surgeon's Certificate**
16 **No. G 35712,**

17 Respondent.

18
19 **PARTIES**

20 1. William Prasifka (Complainant) brings this Accusation solely in his official capacity
21 as the Executive Director of the Medical Board of California, Department of Consumer Affairs
22 (Board).

23 2. On or about October 17, 1977, the Medical Board issued Physician's and Surgeon's
24 Certificate Number G 35712 to Donald Clyde Willis, M.D. (Respondent). The Physician's and
25 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
26 herein and will expire on June 30, 2021, unless renewed.

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JURISDICTION

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

1 appropriate for that negligent diagnosis of the patient shall constitute a single
2 negligent act.

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

8 (d) Incompetence.

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

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

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

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

19 FIRST CAUSE FOR DISCIPLINE

20 (Gross Negligence)

21 7. Respondent's Physician's and Surgeon's Certificate Number G 35712 is subject to
22 disciplinary action under section 2227, as defined by section 2234, subdivision (b), in that he
23 committed act(s) and/or omission(s) constituting gross negligence. The circumstances are as
24 follows:

25 8. At all times relevant to this Accusation, Respondent practiced at Family Planning
26 Associates (FPA) at various clinics throughout California, including Bakersfield. Respondent's
27 duties included performing surgical abortions. Respondent currently only practices gynecology
28 in an office setting in Fresno and Modesto, and ceased the surgical side of his practice
approximately three years ago. Respondent is Board Certified in obstetrics and gynecology.

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1 Patient A¹

2 9. On or about February 3, 2017, Patient A presented to Respondent at approximately 28
3 years old, G2P1, desiring an abortion. An ultrasound examination revealed the gestational age to
4 be approximately 17 3/7 weeks. Respondent placed three dilapan osmotic dilators, and scheduled
5 Patient A for a dilation and evacuation procedure the following day.

6 10. On or about February 4, 2017, Patient A presented for her dilation and evacuation
7 procedure. The procedure itself was uncomplicated, and Respondent placed a Nexplanon
8 contraceptive device at the conclusion of the procedure. Postoperatively, Patient A's bleeding
9 began to increase. Respondent took Patient A back to the operating room, re-aspirated, and under
10 ultrasound, a small amount of additional tissue was removed. Postoperatively, ultrasound
11 revealed additional bleeding outside Patient A's uterus measuring approximately 6x5x3 cm.
12 Respondent believed that this was intraperitoneal bleeding from perforation or adnexal bleeding
13 secondary to "stretching of tissue." Respondent transferred Patient A to the hospital. The
14 hospital did not find any evidence of intraperitoneal bleeding, signs of perforation, or free air.
15 Patient A's blood count and vital signs remained stable, and she was eventually discharged.
16 Respondent failed to document numerous pertinent facts in the medical record of Patient A
17 related to her dilation and evacuation procedure. Respondent did not document the size of the
18 dilator or the curette used in the operation. Respondent did not document the type of forceps
19 used for decompression. Respondent did not document a description of the fetal tissue removed
20 in regards to fetal parts in a operation that involved respiration. Respondent did not document an
21 operative note for Patient A's respiration. In addition to the missing documentation in the
22 operative note, Respondent's medical records for Patient A include many blank spaces on the
23 preprinted medical record forms. Respondent did not document the Nexplanon insert within the
24 handwritten portion of the dilation and evacuation procedure, although it is electronically entered
25 in a separate section of the medical record. Respondent repeatedly failed to document pertinent
26 information in the medical record of Patient A, which constitutes gross negligence.

27
28 ¹ To protect the privacy of the patient involved, the patient's name has not been included
in this pleading. Respondent is aware of the identity of the patient referred to herein.

1 Patient B

2 11. On or about August 19, 2017, Patient B presented to Respondent at approximately 23
3 years of age, G2P1, seeking an abortion. Respondent determined her gestational age to be
4 approximately 14 2/7 weeks. Towards the end of the procedure, Respondent noted that Patient B
5 was suddenly jerking, and the tenaculum caused a tear of the cervix with subsequent blood loss of
6 approximately 200 ml. Respondent determined that he could not obtain the needed exposure and
7 visualization at the clinic to address the bleeding due to Patient B's morbid obesity. Respondent
8 called an ambulance and transferred Patient B to the hospital. Respondent was uncertain if the
9 calvarium was in Patient B's uterus or vagina at the time of transfer. At the hospital, the
10 emergency room staff immediately requested an OBGYN consultation, and Patient B was taken
11 to the operating room for completion of the surgery. Tissue was removed by suction curettage,
12 and the pathology report stated that "fetal tissue" was part of the specimen recovered. Patient B
13 recovered without complication, and was discharged from the hospital.

14 12. Respondent did not document what was removed, and what was not removed ruling his
15 incomplete dilation and evacuation surgery prior to transferring Patient B to the hospital.
16 Respondent's failure to document these details, prevents subsequent physicians from knowing if
17 the termination was completed. Respondent's failure to document what tissues were removed
18 during surgery prior to transferring Patient B to the hospital constitutes gross negligence.

19 Patient C

20 13. On or about October 3, 2017, Patient C presented to Respondent for an abortion at 23
21 years of age, G4P3, with a history of two prior cesarean sections. Respondent estimated the
22 gestational age to be approximately 11 1/7 weeks. Respondent performed the surgery using
23 Hegar dilators to dilate the opening to 11 mm, and a #11 cannula vacuum for suction, despite not
24 being able to clearly visualize the external os of the cervix. During surgery, no tissue passed,
25 blood loss was estimated at 500 ml, but there was no bleeding observed from her vagina.
26 Respondent did not document any fetal tissue removed from Patient C. Patient C's vital signs
27 became unstable, 911 was called, and she was transferred to the hospital. Patient C was treated
28 for hemorrhagic shock at the hospital, and imaging revealed a right adnexal mass consistent with

1 an intraperitoneal hematoma. Patient C received 4 units of blood and proceeded to surgery. In
2 surgery, Patient C suffered a cardiac arrest, was successfully resuscitated. The surgeons
3 conducted an exploratory laparotomy, total abdominal hysterectomy, right salpingo-
4 oophorectomy for a right sided uterine perforation and extensive damage to the right ovary and
5 right fallopian tube. Patient C's pregnancy was removed with the uterus, and she received 10
6 additional units of blood. Five days later, on October 8, 2017, Patient C was discharged from the
7 hospital.

8 14. Respondent did not document an operative note for Patient C's surgery. Although
9 there is a later entry in the medical record that Respondent suffered an injury, there is no
10 documentation to correct or complete the operative note for Patient C's operation. Respondent's
11 failure to document an operative note for Patient C's operation constitutes gross negligence

12 15. Respondent did not take into account potential risk factors for Patient C's surgery.
13 Respondent should have considered any unstable vital signs, abnormal anatomy, medication use,
14 or previously unspecified allergies. Respondent did not visual a normal cervical opening during
15 Patient C's procedure, and was unable to perform the surgery safely without imaging or other
16 assistance. Respondent could have rescheduled the surgery so that he could have the imaging
17 assistance needed, but he elected to proceed by blindly dilating where he believed the cervical
18 opening was located. Respondent perforated the uterus on the right side, causing major injury to
19 the large vessels of the ovary and fallopian tube during the dilation, suction or both. Respondent
20 characterized his error as causing the perforation, failing to recognize the error of proceeding
21 blindly in surgery on a patient with distorted anatomy. Respondent's decision to proceed with
22 Patient C's abortion, without the ability to discern the pathway to her uterus constitutes gross
23 negligence.

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1 3. Ordering Donald Clyde Willis, M.D., if placed on probation, to pay the Board the
2 costs of probation monitoring; and

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

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5 DATED: **AUG 07 2020**



WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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