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

In the Matter of the Accusation Against: Rakhee N. Shah, M.D. Physician's and Surgeon's Certificate No. A 90744 Respondent.	Case No.: 800-2017-037477

DECISION

The attached Proposed Decision 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 August 19, 2021.

IT IS SO ORDERED: July 20, 2021.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

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

In the Matter of the Accusation Against:

RAKHEE N. SHAH, M.D.,

Physician's and Surgeon's Certificate No. A 90744

Respondent.

Agency Case No. 800-2017-037477

OAH No. 2020120273

PROPOSED DECISION

Administrative Law Judge Karen Reichmann, State of California, Office of Administrative Hearings, heard this matter on April 26-29, 2021, by videoconference.

Deputy Attorney General Carolyne Evans represented complainant William Prasifka, Executive Director of the Medical Board of California.

Robert Hodges, Attorney at Law, appeared on behalf of respondent Rakhee N. Shah, M.D., who was present.

The record closed and the matter was submitted for decision on April 29, 2021.

FACTUAL FINDINGS

Background

1. On April 1, 2005, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A 90744 to respondent Rakhee N. Shah, M.D. The certificate was in full force and effect at all times relevant to the charges in the accusation. It is scheduled to expire on January 31, 2023, unless renewed. This is the first disciplinary action against respondent's certificate.

2. On December 27, 2018, Kimberly Kirchmeyer issued this accusation solely in her official capacity as the Executive Director of the Board. William Prasifka subsequently replaced Kirchmeyer as the Board's Executive Director and the complainant in this matter. Respondent filed a timely notice of defense, and this hearing followed.

3. Complainant seeks to discipline respondent based on four surgical procedures she performed in 2016. Complainant alleges that respondent committed repeated acts of negligence and one act of gross negligence in connection with these procedures.

Respondent's Educational and Professional Background

4. Respondent was educated in Gujarat, India. She completed post-graduate training in India and Europe before moving to the United States. She completed a general surgery residency in Kansas City in 2005, followed by a one-year fellowship in minimally invasive surgery in Oakland. Respondent has been board-certified in general surgery since 2005; she recertified in 2014.

5. In 2006, respondent joined an established surgical practice in Pleasanton consisting of two other physicians. She was granted hospital privileges at ValleyCare Medical Center and San Ramon Regional Medical Center.

6. In addition to performing elective surgical procedures, respondent regularly took emergency call at both hospitals. All four surgical procedures in this case arose from laparoscopic procedures respondent performed while on call at ValleyCare. Respondent came to the Board's attention by way of two reports filed by the hospital pursuant to Business and Professions Code section 805. The Board conducted an investigation, which included an interview of respondent by an investigator and medical consultant on April 23, 2018. Respondent also submitted two follow-up letters to the Board after the interview.

Medical Experts

7. The parties each presented testimony and written reports by highly experienced medical experts.

DR. TERUYA

8. Complainant's expert, Theodore Teruya, M.D., is board-certified in general and vascular surgery. He is on the faculty at Loma Linda University Medical Center, University of California, Riverside, and the University of Hawaii. He has served as an expert witness for the Board since 2010 and has reviewed approximately 15 cases in this capacity.

Dr. Teruya's opinions were based on his review of the four patients' medical records and of the transcript of respondent's interview with the Board's investigator, as well as the two follow-up letters respondent sent to the investigator. Dr. Teruya also

reviewed a copy of Dr. Gardiner's (respondent's expert) report prior to testifying at the hearing. In fact, Dr. Teruya modified his opinion regarding one of the patients after reading Dr. Gardiner's report.

DR. GARDINER

9. Respondent retained Barry Gardiner, M.D., as her expert. He has practiced for more than 50 years, and has been a pioneer in minimally invasive surgery in the Bay Area.

Dr. Gardiner has a pre-existing professional relationship with respondent. They both have hospital privileges at San Ramon Regional Medical Center, although they are not in the same call group. They have reviewed each other's cases as part of San Ramon's quality assurance process.

Dr. Gardiner reviewed the patients' medical records and the transcript of respondent's interview. He also had access to the CT scans (as opposed to just the radiologist's reports), unlike Dr. Teruya. In addition, he personally interviewed respondent about the incidents and relied heavily on her statements during this interview in reaching his conclusions. Dr. Gardiner also read Dr. Teruya's report prior to writing his own report in this matter.

Surgical Complications at ValleyCare in 2016

PATIENT #1

10. On January 25, 2016, respondent performed a cholecystectomy (gallbladder removal) and intraoperative cholangiogram (IOC) procedure on a 41-year old female patient admitted through the emergency room. The IOC procedure is performed by inserting a catheter into the cystic duct and injecting a contrast dye to

determine whether there are obstructions in the ducts and to help define the patient's anatomy. It was performed, in part, to determine whether a second gallstone was present in the area of the small intestine. If respondent identified a stone, a gastroenterologist was prepared to perform a separate procedure on the patient to remove it.

Respondent visualized the contrast dye flowing down into the duodenum, indicating no obstruction. She did not visualize the dye flowing up into the two hepatic ducts. She believed the passage was occluded by a surgical balloon, but she did not deflate the balloon, and she did not redo the IOC or investigate further. Doing any of these things might have enabled her to better visualize the hepatic ducts and lessened the likelihood of an injury to the common bile duct.

The procedure was complicated by the anatomy and location of the gallbladder and the presence of inflammatory tissue. Respondent injured the patient's common bile duct during surgery. The patient was transferred to another hospital for surgical repair of this duct by a hepatic specialist.

Expert Opinion

11. Both experts agreed that respondent committed a simple departure from the standard of care in her treatment of Patient #1. Specifically, the experts concur that respondent's failure to properly interpret the IOC results constituted a simple departure. They agree that respondent should have repeated the study to make sure she visualized the patient's hepatic ducts, and agreed it was likely that respondent placed the catheter in the wrong duct. Re-doing the IOC would have helped respondent properly visualize the anatomy and would have reduced the likelihood of damage to the patient's common bile duct during the cholecystectomy procedure.

PATIENT #2[1]

12. Patient #2 was an obese 18-year-old male who was admitted to the emergency room on July 11, 2016, complaining of a three-day history of abdominal pain that had localized in the right lower quadrant, as well as nausea, vomiting, and diarrhea. A CT scan revealed that the appendix was thickened and folded, but with no surrounding inflammation, with the radiologist commenting, "Correlate clinically for appendicitis." The patient was afebrile and his white blood cell count was moderately elevated.

Respondent diagnosed the patient with acute appendicitis and obtained consent from the patient to perform a laparoscopic appendectomy. During the procedure, respondent had difficulty locating the appendix. She located a structure that was folded, and she believed it might be the appendix, although she was not certain. She removed the structure with a surgical stapler and terminated surgery. She did not examine the structure; it was sent to pathology and later determined not to be the appendix. Respondent did not convert the surgery to an open surgery, which would have enabled her to correctly identify and remove the appendix. Respondent documented a post-operative diagnosis of acute appendicitis.

The patient was discharged the following day. He returned to the hospital with abdominal pain a few days later; however, it was determined that he suffered from food poisoning and not appendicitis. Imaging performed during this second

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[1] At hearing, the following allegations regarding Patient #2 were stricken from the accusation: 1) the first sentence of paragraph 14; and 2) paragraph 15 (a).

hospitalization showed staples from respondent's prior procedure, and confirmed that the appendix was still present.

Expert Opinions

13. Dr. Teruya concluded that respondent's failure to convert to an open surgical procedure and successfully identify and remove the patient's appendix constituted an extreme departure from the standard of care. Dr. Teruya explained that having diagnosed acute appendicitis and having made the decision to perform surgery on Patient #2, respondent believed that it was medically necessary to remove the appendix. In these circumstances, a physician has a duty to the patient to be sure the procedure is needed and to then accomplish the procedure. Untreated acute appendicitis can be fatal; by terminating surgery without making sure she had removed the appendix, respondent created a risk of great harm to the patient. Dr. Teruya added that when respondent removed the structure she thought might be the appendix, she should have examined it. In his opinion, aborting the procedure without accomplishing the objective of removing the appendix was an extreme violation of the standard of care. Without ever locating the appendix, she had no way of knowing whether it was infected. Dr. Teruya believes that respondent subjected the patient to all of the risks of surgery without conferring the benefit of the surgery.

14. Dr. Gardiner concluded that respondent's conduct did not violate the standard of care in any respect. He opined that respondent acted reasonably in terminating the procedure after removing a structure which resembled the appendix as described on the radiologist's report, and without converting to an open surgery, in light of the lack of signs of an active infection. He described respondent as thoughtful and careful in her treatment of the patient. He believes that converting the surgery to an open surgery would have presented serious risks to the patient, including risk of

infection and hernia, and that respondent appropriately balanced the risks in her decision making.

PATIENT #3

15. Patient #3 was a 73-year-old female who was admitted to the hospital with left lower quadrant pain. She was diagnosed with diverticulitis and treated with antibiotics for several days. Her condition did not improve and a Hartmann's procedure (surgical resection of the rectosigmoid colon and creation of a colostomy) was recommended.

Respondent performed the Hartmann's procedure on Patient #3 on November 30, 2016. During the procedure, respondent was unable to identify the entire structure of the patient's left ureter because it was partly embedded in a large woody mass of inflamed tissue. Despite her efforts to avoid the ureter during the Hartmann's procedure by keeping her surgical instruments close to the wall of the colon, the ureter was transected. Respondent realized the injury during surgery and a urologist was summoned to repair the transected ureter prior to respondent completing the Hartmann's procedure. Patient #3 experienced significant post-surgical complications.

Expert Opinions

16. Dr. Teruya concluded that respondent's transection of the patient's ureter constituted a simple departure from the standard of care. He acknowledged that injury to the ureter during colon surgery is a known, but rare, complication. In reaching his conclusion, he noted a lack of extenuating circumstances and the fact that respondent, in her interview and letter to the Board, identified additional measures she could have taken to try to prevent the injury, including the use of a stent.

17. Dr. Gardiner did not find a departure from the standard of care. He agreed with Dr. Teruya that ureteral injury is a known complication of the surgical procedure that cannot always be prevented. He concluded that there were extenuating circumstances in the case of Patient #3 which can result in injury to the ureter at the hands of a reasonable and prudent surgeon.

PATIENT #4

18. Patient #4 was a 72-year-old female who arrived in the emergency room late on July 6, 2016 complaining of abdominal pain. She was diagnosed with acute diverticulitis with a microperforation. Respondent examined the patient in the emergency room on the morning of July 7. She recommended conservative treatment, consisting of IV hydration, antibiotics, and observation. The patient was admitted to the hospital.

The patient's condition deteriorated the following day and she was transferred to the ICU. Respondent was not initially informed of this development. Respondent became aware that Patient #4's condition had deteriorated when doing rounds on the afternoon of July 8. The patient was in sepsis, her white blood count was significantly elevated, and she was being treated with vasopressors.

Respondent believed it was very obvious that the patient needed surgery, and was ready and willing to perform surgery that evening. However, the ICU doctor wanted respondent to wait until the following day. He feared that the patient was not in good enough condition to survive the surgery, and hoped to stabilize the patient with hydration and antibiotics. He also wanted an additional CT scan and to consult other specialists. Respondent preferred to proceed with surgery and had no need for a further scan or additional consultation, but deferred to the ICU doctor's treatment

plan. Respondent documented the treatment plan but did not document that it was formulated by the ICU doctor and did not document her disagreement with the treatment plan.

Respondent was worried about the patient's condition and called the hospital several times during the night. She made arrangements to have the CT scan performed as early as possible and to secure the first spot on the operating room schedule for the following morning. Respondent performed the Hartmann's procedure on Patient #4 on the morning of July 9. The patient suffered significant post-surgical complications.

Expert Opinions

19. Dr. Teruya testified that the standard of care requires that a patient in deteriorating condition with an identified source of infection must be taken for surgery immediately. He concluded that the delay of more than 12 hours from when respondent became aware that the patient was in sepsis constituted a departure from the standard of care. In his opinion, any reasonable surgeon would have performed emergency surgery within two hours of discovering the patient's condition on the afternoon of July 8. The delay posed an extreme risk to the patient, who could have died awaiting surgery, and who may have suffered more severe post-surgical complications. Dr. Teruya added that a physician has a duty to advocate for the patient, and cannot allow a patient to suffer because another physician is making a poor decision.

Dr. Teruya acknowledged that the opposition of the ICU doctor constituted a barrier and that for this reason he determined that respondent's conduct constituted a simple, rather than extreme, departure from the standard of care.

20. Dr. Gardiner relied heavily on his interview with respondent in forming his opinions. He agreed that based solely on the medical records, he would have found a deviation from the standard of care. Dr Gardiner ultimately concluded that it was appropriate for respondent to defer the decision regarding the timing of surgery to the ICU doctor, and that she did not deviate from the standard of care by doing so. He explained that the ICU doctor was responsible for managing the patient's physical condition and had authority over the timing of the surgical procedure. He added that respondent should have better documented that it was a team decision in the medical record, but also stated that doctors are taught not to document disagreements in patient records and her failure to do so was not a deviation from the standard of care.

Respondent Completes the PACE Program

21. In September 2017, ValleyCare's medical executive committee suspended respondent's privileges and directed respondent to complete the Physician Assessment and Competency Evaluation (PACE) program at UC San Diego. Respondent participated in the PACE program from December 4 through 8, 2017.

The PACE program prepared a summary of her performance and contained recommendations. Respondent was assessed at the program's Category 2, which signifies that minor deficiencies were noted. The PACE summary noted:

> Overall, [respondent's] performance on the physician assessment was satisfactory and at times excellent. [Respondent] demonstrated satisfactory medical interviewing and physical examination skills during the mock patient encounter. She performed superiorly on the oral examination in general surgery.....She managed the

> hypothetical patients safely and successfully, demonstrating solid knowledge and clinical judgment . . . [H]er chart notes were of average quality for a busy surgeon During clinical observation and case discussions her judgment and decision-making were excellent. [Respondent] performed very well on the laparoscopic simulation and performed satisfactorily on the suturing simulation. [Respondent].....generally demonstrated very good medical knowledge and clinical judgment.

The report concluded that respondent appeared to be a competent general surgeon. However, because the allegations involved technical skills that could not be thoroughly assessed within the limitations of the PACE program, it was recommended that respondent undergo proctoring upon her return to practice. Specifically, PACE recommended that respondent have her first five cases involving laparoscopic procedures and her first five cases involving urinary structures proctored. It was also recommended that respondent incorporate some changes in her medical recordkeeping.

22. After respondent completed the PACE program, the ValleyCare medical executive committee notified her that it would be following the recommendations, and directed that respondent be proctored during her first five laparoscopic abdominal surgery cases and first five cases involving the ureter.

Respondent encountered obstacles arranging for a proctor and ultimately elected not to renew her privileges at ValleyCare.

Respondent's Evidence

RESPONDENT'S TESTIMONY

23. In contrast to statements made to the Board's investigator in which she acknowledged making errors, at hearing respondent was reluctant to acknowledge any errors and disputed deviating from the standard of care with respect to all four patients.

24. Respondent stated that 2016, the year the incidents occurred, was an extremely busy year for her medical practice. After taking some time off the prior year, she felt obligated to take extra hospital calls for the surgeons who had covered for her.

25. Respondent reported that Patient #1's case "significantly impacted" her. She added that she thought during the procedure that she had a good view of the patient's anatomy, and she thinks she managed the patient appropriately. She added that she now "goes back to basics" and makes sure to perform a complete IOC, visualizing the dye in both directions. Respondent is not sure whether her error influenced the outcome in Patient #1's case.

26. Respondent feels she made the right decision in her treatment of Patient #2. She did not believe there was a justification to convert to an open appendectomy because she saw no signs of infection intraoperatively. Respondent explained that she did not examine the tissue she removed during the procedure, because identifying whether it was in fact the appendix would not have changed her decision to terminate the procedure. She noted that there are risks inherent to an open appendectomy, including a longer hospital stay, a bigger incision, exposure to more anesthesia, the need for more pain medications post-operatively, and risks of infection, bleeding hernia, anastomoses, and bowel blockage. She believed that if needed, she could have

performed a second surgery later should the patient have exhibited further symptoms of appendicitis.

Respondent acknowledged that she made an error by documenting a post-operative diagnosis of acute appendicitis, stating that she should have written "right lower quadrant pain of uncertain etiology" instead.

Respondent has performed more than 429 laparoscopic appendectomies since 2013, including more than188 appendectomies since operating on Patient #2 in July 2016. She reported that she successfully located and removed the appendix during these procedures.

27. Respondent denied that the transection of Patient #3's ureter was the result of negligence. She acknowledged that some surgeons have other ideas to prevent ureteral injury, but she does not believe the standard of care required her to act any differently than she did when performing the Hartmann's procedure.

28. Regarding Patient #4, respondent stated that she was not at fault. She acknowledged that she had a difference of opinion with the ICU doctor, but she trusted and relied on him despite her concerns. She denied that the delay caused the patient's post-surgical complications, and she does not believe that the delay made any difference in the patient's outcome.

29. In 2017, respondent moved closer to the San Ramon area where she works, reducing travel time and stress. Her two partners retired so she is now in solo practice. She currently is only taking hospital call at San Ramon Regional Center.

OTHER EVIDENCE

30. Christina Hopson, D.O., testified at hearing and wrote a letter on behalf of respondent. She is an infectious disease specialist and was involved in the care of Patient #4. She described the decision to delay surgery on the patient as a team decision, and she does not believe there was a violation of the standard of care.

Dr. Hopson wrote that she has had many mutual patients with respondent and has found respondent to be responsive, conscientious, compassionate, competent, knowledgeable, and collegial.

31. Philip A. Wolfe, M.D., is a gastroenterologist at ValleyCare who has shared many patients with respondent since 2006. He was involved in the treatment of Patient #1. In a letter to the Board, he stated that the complications in all cases he has been involved with involving respondent appeared to him to be isolated incidents. He wrote, "I would like to emphasize the confidence that I have had and continue to have in the care provided by [respondent]."

32. Respondent submitted numerous reference letters. She explained that it was an embarrassing process for her to ask for the letters, and that she explained the allegations to all letter writers. The letters were primarily written in 2018, prior to the issuance of the accusation.

a. Raman N. Nambisan, M.D., was respondent's partner in her surgical group. He wrote that respondent exhibited sound clinical knowledge and judgment, strong surgical skills, and good interpersonal skills, and worked tirelessly on behalf of her patients. Dr. Nambisan worked together with respondent in surgery many times and observed her to be competent, poised, and thoughtful. He believes that the complications involved in cases at issue are typical of a surgeon with a high volume of

emergency room cases. He also praised the humility and grace with which she handled being under scrutiny by ValleyCare and the Board. He does not believe that she had a need for proctoring. He added that respondent's work-family balance had improved after she stopped working at ValleyCare and was only taking emergency call at one hospital instead of two. He also noted that all surgeons, including himself, encounter complications in their practice.

In a separate letter, Dr. Nambisan discussed the allegations in the accusation and expressed his view that respondent's conduct did not deviate from the standard of care. He believes the cases are "reflections of the broad spectrum of complex surgical procedures that a Surgeon encounters in the community setting." He added that respondent is a diligent and passionate surgeon, and that the community has benefited from her services.

b. Chau V. Dang, M.D., was respondent's other partner in her surgical practice. He retired in 2015. Dr. Dang wrote that respondent was conscientious and showed great empathy towards patients, and that she was well-liked.

c. Michael Gottlieb, M.D., is the Chief of Surgery at San Ramon Regional Medical Center. He has known respondent for more than 10 years. He is aware of respondent's history with ValleyCare, the cases at issue, the 805 report, the PACE report, and the Board's investigation. San Ramon Regional Medical Center imposed no restrictions on respondent's hospital privileges. He has personally worked with her in surgery with no issues. He added that in deciding not to restrict her privileges, the hospital recognized that a practice such as respondent's that is heavily weighted towards emergency surgery may be more likely to have complications due to the patients' presenting conditions.

d. Narendra Malani, M.D., is a pulmonologist and critical care specialist with 30 years' experience. Dr. Malani has known respondent since 2006 and has worked with her at both hospitals. Dr. Malani described respondent as highly qualified, experienced and diligent. He has never had any concerns about respondent's quality of care, medical management, or treatment decisions.

e. Gary Sloan, the Chief Executive Officer of San Ramon Regional Medical Center, has known respondent since 2006. He confirmed that she is a committed surgeon in good standing at the hospital. He praised her engaging personality, collegiality, professionalism, and quality care and service to her patients.

f. Radhika Annadata, M.D., is an anesthesiologist. She has known respondent since 2006 and has worked with her at both ValleyCare and San Ramon Medical Center. Dr. Annadata described respondent as a competent and caring surgeon with sound clinical judgment, integrity, and compassion.

g. Lorena H. Tan, M.D., is the Chief of Family Medicine at ValleyCare. She has known respondent since 2006. Dr. Tan has felt comfortable referring patients to respondent. Dr. Tan was aware of the cases in this accusation. She wrote that respondent has an open mind and is striving to be a great surgeon and to learn from the complications.

h. T. Peter Wong, M.D., is a family medicine doctor affiliated with ValleyCare. He has known respondent since 2006 and has referred many patients to her. He wrote that respondent is an excellent surgeon with good judgment who interacts well with patients and medical colleagues.

i. Michael L. Wynn, M.D., is a surgeon at San Ramon Regional Medical Center. He has known respondent since 2006. He wrote that she is a competent

surgeon who is respected by peers and hospital staff. He noted that all surgeons have complications, and he believes that respondent makes the best clinical decisions based on the information available.

j. Six members of the surgical staff (nurses and scrub techs) at ValleyCare submitted a joint letter in support of respondent, writing that she was admired and respected by the surgical staff and possessed a calm demeanor, sound clinical judgment, and strong surgical skills.

33. Respondent has attended numerous continuing education courses since the time of the four incidents. She attended week-long programs presented by the Society of American Gastrointestinal and Endoscopic Surgeons in 2017 and 2019. She completed 90 hours of surgical education and self-assessment through the American College of Surgeons in 2017 and 109 hours in 2020. In 2019, she completed a four-day symposium in minimally invasive surgery presented by the University of Cincinnati.

Ultimate Findings re: Standard of Care/Causes for Discipline

34. Because the facts underlying the four surgical procedures are largely undisputed, the determination of the causes for discipline depends on an assessment of the two experts.

Dr. Teruya was found to be a persuasive witness. His conclusions were well-reasoned and supported by the evidence. Dr. Teruya acknowledged aspects of the cases that were difficult, and he was willing to modify his conclusions after reading Dr. Gardiner's report.

Dr. Gardiner's opinions were far less persuasive. Dr. Gardiner's opinions were based primarily on his own interview of respondent and based on additional details

she provided that were not documented in the medical records and not provided during her interview with the Board's investigator. Additionally, Dr. Gardiner had a pre-existing professional relationship with respondent that both he and respondent minimized. He acknowledged, however, that respondent had called him the night before he testified. The appearance of Dr. Gardiner's bias was furthered by a letter he wrote on respondent's behalf in which he expressed disappointment with the Board's delay in disciplining her and his concerns about the financial impact that probation would have. Dr. Gardiner also misrepresented his experience as an expert reviewer for the Board on his curriculum vitae, which states that he has reviewed cases for the Board from "1997 to the present." In fact, he could not recall a single case he reviewed for the Board and did not contradict complainant's assertion that he had not reviewed a case for the Board for at least 24 years.

Based on the persuasive testimony and report of Dr. Teruya, it was established, by clear and convincing evidence, that respondent committed simple negligent acts in her treatment of Patient #1, Patient #3, and Patient #4, and an act of extreme negligence in her treatment of Patient #2, as set forth in Findings 11, 13, 16, and 19.

LEGAL CONCLUSIONS

1. It is complainant's burden to demonstrate the truth of the allegations by "clear and convincing evidence to a reasonable certainty," and that the allegations constitute cause for discipline of respondent's certificate. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App.3d 853, 856.)

2. The Board may take disciplinary action for unprofessional conduct (Bus. & Prof. Code, § 2234); for gross negligence (*id.*, subd. (b)); and for repeated negligent

acts (*id.*, subd. (c)). Cause exists to discipline respondent's certificate pursuant to these statutes, in light of the matters set forth in Finding 34.

3. Cause for discipline having been established, the issue is determining the appropriate discipline. In exercising its disciplinary functions, protection of the public is the Board's highest priority. (Bus. & Prof. Code, § 2229, subd. (a).) The Board is also required to take disciplinary action that is calculated to aid the rehabilitation of the physician whenever possible, as long as the Board's action is not inconsistent with public safety. (Bus. & Prof. Code, § 2229, subds. (b), (c).)

4. The Board's Manual of Disciplinary Orders and Disciplinary Guidelines (12th ed., 2016; Cal. Code Regs., tit. 16, § 1361) provide for a minimum discipline of five years' probation and a maximum penalty of revocation as the recommended penalties for unprofessional conduct, gross negligence, and repeated negligent acts.

Complainant recommended a five-year period of probation, including an education course in abdominal surgeries and complications and a practice monitor. Respondent asserted that if cause for discipline was established, a letter of reprimand would be the maximum appropriate discipline.

5. Respondent committed negligent acts in connection with four surgical procedures on four different patients, raising concerns about her technical skills and clinical judgment. In the case of Patient #4, respondent failed to advocate for her patient in an effective manner. In each case, the patient was put at serious risk of harm as a result of her conduct. Respondent continues to defend her actions and does not acknowledge that she deviated from the standard of care. She successfully completed the PACE assessment; however, she failed to satisfy PACE's recommendation that she

be proctored during 10 subsequent procedures for a firsthand assessment of her technical skills.

Under these circumstances, complainant's recommendation is deemed appropriate. Protection of the public requires that respondent undergo a period of probation, including additional education in abdominal surgery and a practice monitor, to ensure that she possesses the skills and judgment to practice within the standard of care.

ORDER

Physician's and Surgeon's Certificate No. A 90744, issued to respondent Rakhee N. Shah, M.D., is revoked; however, revocation is stayed, and respondent is placed on probation for five years under the following terms and conditions.

1. Notification

Within seven days of the effective date of this Decision, respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities, or insurance carrier.

2. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

3. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

4. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

5. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice: Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

6. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

7. Non-Practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice,

respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

8. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

9. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

10. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender her certificate. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

11. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

12. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

13. Practice Monitor

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be

expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether

respondent's practices are within the standards of practice medicine, and whether respondent is practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

DATE: 05/27/2021

Karen Reichmann
KAREN REICHMANN

Administrative Law Judge

Office of Administrative Hearings

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

In the Matter of the Accusation Against: **Rakhee N. Shah, M.D.** **5575 W. Las Positas, Ste. 270** **Pleasanton, CA 94588** **Physician's and Surgeon's Certificate No. A 90744,** Respondent.	Case No. 800-2017-037477 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this 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 April 1, 2005, the Medical Board issued Physician's and Surgeon's Certificate Number A 90744 to Rakhee N. Shah, 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 January 31, 2021, unless renewed.

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 unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states, in pertinent part:

"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.

CAUSE FOR DISCIPLINE

(Gross Negligence and/or Repeated Negligent Acts)

6. At all relevant times, Respondent was practicing as a general surgeon at a hospital in California. Respondent is subject to disciplinary action under sections 2234 and/or 2234(b) and/or 2234(c) in that Respondent engaged in unprofessional conduct and/or was grossly negligent and/or repeatedly negligent in her care and treatment of patients P-1, P-2, P-3, and P-4.[1] The circumstances are as follows:

Patient P-1

7. In January 2016, Patient P-1 was a then 41-year-old female patient, who presented to the hospital with abdominal pain. She had an ultrasound that demonstrated gallstones and extrahepatic[2] duct dilatation. She also had jaundice and elevated liver function tests.

8. On or about January 25, 2016, Respondent performed a laparoscopic cholecystectomy[3] with intraoperative cholangiogram[4]. The cholangiogram demonstrated flow into the duodenum without obstruction. The proximal hepatic radicles were not visualized. The patient had bile leakage after her gallbladder was removed.

9. Postoperatively, Patient P-1 had a high bilious drain output (excessive bile secretion). An endoscopic retrograde cholangiopancreatography (ERCP)[5] with sphincterotomy[6] was performed and a bile leak was confirmed. The patient had a magnetic resonance cholangiopancreatogram that demonstrated no hepatic duct dilation.

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[1] The patients are designated in this document as Patients P-1 through P-4 to protect their privacy. Respondent knows the names of the patients and can confirm their identities through discovery.

[2] Extrahepatic is a duct tube that is outside the liver and carries bile from the liver and gallbladder to the small intestine.

[3] A cholecystectomy is a surgical procedure to remove the gallbladder.

[4] A choloangiogram is a special x-ray procedure that is done with contrast media to visualize the bile ducts after a cholecystectomy.

[5] Endoscopic retrograde cholangio-pancreatography is a diagnostic procedure used to examine diseases of the liver, bile ducts, and pancreas.

[6] A sphincterotomy is a surgical procedure in which the sphincter is cut or stretched.

10. During the gallbladder removal surgery, Respondent failed to recognize that the cholangiogram catheter was in the common bile duct. The catheter should have been placed in the cystic duct. As a result of the incorrect placement of the catheter, Patient P-1 sustained a common bile duct injury. She was subsequently transferred to another facility for a higher level of care.

11. Respondent's overall acts, and/or omissions, with regard to Patient P-1, constitutes unprofessional conduct/negligence in that Respondent failed to recognize the incorrect placement of the catheter in the patient's common bile duct.

Patient P-2

12. In 2016, Patient P-2 was a then 18-year-old male who presented to the hospital with right lower quadrant pain. He had a computed tomographic (CT) scan that demonstrated a thickened appendix without inflammation. An appendicolith[7] was present.

13. On or about July 11, 2016, Respondent performed a laparoscopic appendectomy even though Patient P-2 did not have inflammation in his appendix. During the procedure, Respondent could not specifically identify the appendix but decided nonetheless to remove a structure that she thought was the appendix. Respondent did not convert the laparoscopic appendectomy to an open procedure to correctly identify and remove the appendix.

14. Post-surgery, Patient P-2 presented with the same right lower quadrant pain that he had experienced pre-surgery. A CT scan demonstrated that the appendix was still present. The patient was treated for gastroenteritis and his symptoms improved.

15. Respondent's overall acts, and/or omissions, with regard to Patient P-2, constitutes unprofessional conduct through gross negligence and/or negligence. More specifically, Respondent is guilty of unprofessional conduct as follows:

a. Respondent failed to ensure that a clear medical indication existed before attempting to remove Patient P-2's appendix; and

b. Respondent failed to convert the laparoscopic appendectomy to an open surgical procedure.

[7] An appendicolith is a calcified deposit within the appendix.

The

Patient P-3

16. In 2016, Patient P-3 was a then 73-year-old female who presented to the hospital with left lower quadrant pain. She had a five-day history of diverticulitis[8] and was placed on antibiotics for four days. A CT scan revealed a focal area of intestinal perforation and she was admitted and treated with intravenous antibiotics. The patient failed to improve and it was recommended that she undergo a Hartman procedure.[9]

17. On or about November 30, 2016, Respondent performed a Hartman procedure. During the sigmoid colon resection, Respondent did not identify the Patient's ureter[10] and as a result transected Patient P-3's ureter. A urologist had to repair the patient's ureteral injury. Post-procedure, the patient developed sepsis, renal failure, and a wound infection.

18. Respondent's overall acts, and/or omissions, with regard to Patient P-3, constitutes unprofessional conduct/negligence in that Respondent failed to identify the ureter during the removal of the sigmoid colon so as to avoid injury to the ureter.

Patient P-4

19. In 2016, Patient P-4 was a then 72-year-old female who presented to the hospital with abdominal pain. A CT scan demonstrated focal perforation of acute diverticulitis. The patient was admitted and treated with intravenous antibiotics. The patient subsequently developed sepsis and hypotension, which required vasopressors. Patient P-4's white blood count jumped from 7.9 to 20.0 and her creatinine increased.

20. On or about July 8, 2016, Respondent evaluated Patient P-4 and despite her significant clinical deterioration, she decided that her abdominal pain had not worsened and did not think that emergency surgery was necessary at that time.

21. On July 9, 2016, Patient P-4 was taken to the operating room for a Hartman's procedure. Abscesses were present, which were drained. During the surgery, an ostomy site was

[8] Diverticulitis is inflammation or infection of small pouches called diverticula that develop along the walls of the intestines.

[9] A Hartman procedure is a surgical resection of the rectosigmoid colon and formation of a colostomy.

[10] Ureter is a duct by which urine passes from the kidney to the bladder.

created in the left lower quadrant, however, the sigmoid colon was diseased with diverticulosis and a second colostomy site was created in the left upper quadrant.

22. Post-operatively, Patient P-4 developed acute kidney injury and required hemodialysis. She also had respiratory failure requiring mechanical ventilation. Her post-operative course was further complicated by retraction of her stoma[11] and she developed a wound infection and an intra-abdominal abscess that required drainage by an interventional radiologist.

23. Respondent's overall acts, and/or omissions, with regard to Patient P-4, constitutes unprofessional conduct/negligence in that Respondent failed to recommend emergency surgery for a patient that had known perforated diverticulitis, sepsis, and significant clinical deterioration.

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 A 90744, issued to Respondent;

2. Revoking, suspending or denying approval of Respondent's authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent, 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:
December 27, 2018

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

[11] A stoma is an opening in the abdomen wall that a surgeon makes in order for waste to leave the body.