

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

**In the Matter of the Accusation Against:**

**Vicente Gilsanz, M.D.**

**Physician's and Surgeon's  
Certificate No. A 33800**

**Respondent.**

**Case No. 800-2019-055850**

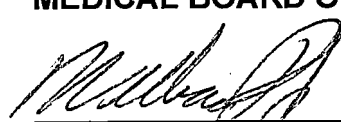
**DECISION**

**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 September 14, 2022.**

**IT IS SO ORDERED September 7, 2022.**

**MEDICAL BOARD OF CALIFORNIA**



**William Prasifka  
Executive Director**

1 ROB BONTA  
Attorney General of California  
2 JUDITH T. ALVARADO  
Supervising Deputy Attorney General  
3 REBECCA L. SMITH  
Deputy Attorney General  
4 State Bar No. 179733  
300 South Spring Street, Suite 1702  
5 Los Angeles, CA 90013  
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*Attorneys for Complainant*  
7

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

12 In the Matter of the Accusation Against:

Case No. 800-2019-055850

13 VICENTE GILSANZ, M.D.  
Radiology Dept. MS #81  
4560 Sunset Blvd.  
14 Los Angeles, CA 90027

**STIPULATED SURRENDER OF  
LICENSE AND ORDER**

15 Physician's and Surgeon's Certificate  
No. A 33800,

16 Respondent.  
17

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

21 **PARTIES**

22 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of  
23 California (Board). He brought this action solely in his official capacity and is represented in this  
24 matter by Rob Bonta, Attorney General of the State of California, by Rebecca L. Smith, Deputy  
25 Attorney General.

26 2. Respondent Vicente Gilsanz, M.D. is represented in this proceeding by attorney  
27 Nicholas Jurkowitz, whose address is 1990 South Bundy Drive, Suite 777, Los Angeles,  
28 California 90025.



1 basis for the charges in the Accusation and that those charges constitute cause for discipline.  
2 Respondent hereby gives up his right to contest that cause for discipline exists based on those  
3 charges.

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

7 **CONTINGENCY**

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

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

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

22 **ORDER**

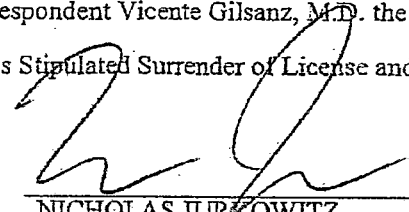
23 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 33800, issued  
24 to Respondent Vicente Gilsanz, M.D., is surrendered and accepted by the Board.

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 I have read and fully discussed with Respondent Vicente Gilsanz, M.D. the terms and  
2 conditions and other matters contained in this Stipulated Surrender of License and Order. I  
3 approve its form and content.

4 DATED: 8-29-22

  
NICHOLAS JURKOWITZ  
Attorney for Respondent

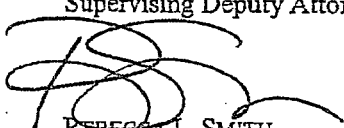
6  
7 **ENDORSEMENT**

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

10 DATED: 8/30/2022

Respectfully submitted,

11 ROB BONTA  
12 Attorney General of California  
13 JUDITH T. ALVARADO  
14 Supervising Deputy Attorney General

  
15 REBECCA L. SMITH  
16 Deputy Attorney General  
17 Attorneys for Complainant

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19 65229107.docx

**Exhibit A**

**Accusation No. 800-2019-055850**

1 ROB BONTA  
Attorney General of California  
2 JUDITH T. ALVARADO  
Supervising Deputy Attorney General  
3 State Bar No. 155307  
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*Attorneys for Complainant*  
6

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

11 In the Matter of the Accusation Against:

Case No. 800-2019-055850

12 **Vicente Gilsanz, M.D.**  
13 **Radiology Dept. MS #81**  
14 **4650 Sunset Blvd.**  
15 **Los Angeles, CA 90027**

**A C C U S A T I O N**

16 **Physician's and Surgeon's Certificate**  
17 **No. A 33800,**

Respondent.

18 **PARTIES**

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

21 2. On or about April 24, 1979, the Board issued Physician's and Surgeon's Certificate  
22 No. A 33800 to Vicente Gilsanz, M.D. (Respondent). The Physician's and Surgeon's Certificate  
23 was in full force and effect at all times relevant to the charges brought herein and expired on  
24 September 30, 2020.

25 **JURISDICTION**

26 3. This Accusation is brought before the Board, under the authority of the following  
27 laws. All section references are to the Business and Professions Code (Code) unless otherwise  
28 indicated.



1 4. Section 118, subdivision (b) of the Code provides:

2 The suspension, expiration, or forfeiture by operation of law of a license issued  
3 by a board in the department, or its suspension, forfeiture, or cancellation by order of  
4 the board or by order of a court of law, or its surrender without the written consent of  
5 the board, shall not, during any period in which it may be renewed, restore, reissued,  
6 or reinstated, deprive the board of its authority to institute or continue a disciplinary  
7 proceeding against the licensee upon any ground provided by law or to enter an order  
8 suspending or revoking the license or otherwise taking disciplinary action against the  
9 licensee on any such ground.

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

11 **STATUTORY PROVISIONS**

12 6. Section 2234 of the Code, states:

13 The board shall take action against any licensee who is charged with  
14 unprofessional conduct.<sup>1</sup> In addition to other provisions of this article, unprofessional  
15 conduct includes, but is not limited to, the following:

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

18 (b) Gross negligence.

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

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

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

(d) Incompetence.

<sup>1</sup> Unprofessional conduct under California and Business Code section 2234 is conduct  
which breaches the rules of the ethical code of the medical profession, or conduct which is  
unbecoming to a member in good standing of the medical profession, and which demonstrates an  
unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564,  
575.)

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

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

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

8 7. Section 2261 of the Code states:

9 Knowingly making or signing any certificate or other document directly or  
10 indirectly related to the practice of medicine or podiatry which falsely represents the  
11 existence or nonexistence of a state of facts, constitutes unprofessional conduct.

12 8. Section 2266 of the Code states:

13 The failure of a physician and surgeon to maintain adequate and accurate  
14 records relating to the provision of services to their patients constitutes unprofessional  
15 conduct.

#### 16 COST RECOVERY

17 9. Section 125.3 of the Code states:

18 (a) Except as otherwise provided by law, in any order issued in resolution of a  
19 disciplinary proceeding before any board within the department or before the  
20 Osteopathic Medical Board, upon request of the entity bringing the proceeding, the  
21 administrative law judge may direct a licensee found to have committed a violation or  
22 violations of the licensing act to pay a sum not to exceed the reasonable costs of the  
23 investigation and enforcement of the case.

24 (b) In the case of a disciplined licensee that is a corporation or a partnership, the  
25 order may be made against the licensed corporate entity or licensed partnership.

26 (c) A certified copy of the actual costs, or a good faith estimate of costs where  
27 actual costs are not available, signed by the entity bringing the proceeding or its  
28 designated representative shall be prima facie evidence of reasonable costs of  
investigation and prosecution of the case. The costs shall include the amount of  
investigative and enforcement costs up to the date of the hearing, including, but not  
limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount  
of reasonable costs of investigation and prosecution of the case when requested  
pursuant to subdivision (a). The finding of the administrative law judge with regard to  
costs shall not be reviewable by the board to increase the cost award. The board may  
reduce or eliminate the cost award, or remand to the administrative law judge if the  
proposed decision fails to make a finding on costs requested pursuant to subdivision  
(a).

(e) If an order for recovery of costs is made and timely payment is not made as  
directed in the board's decision, the board may enforce the order for repayment in any  
appropriate court. This right of enforcement shall be in addition to any other rights  
the board may have as to any licensee to pay costs.

1 (f) In any action for recovery of costs, proof of the board's decision shall be  
conclusive proof of the validity of the order of payment and the terms for payment.

2 (g) (1) Except as provided in paragraph (2), the board shall not renew or  
3 reinstate the license of any licensee who has failed to pay all of the costs ordered  
under this section.

4 (2) Notwithstanding paragraph (1), the board may, in its discretion,  
5 conditionally renew or reinstate for a maximum of one year the license of any  
6 licensee who demonstrates financial hardship and who enters into a formal agreement  
with the board to reimburse the board within that one-year period for the unpaid  
costs.

7 (h) All costs recovered under this section shall be considered a reimbursement  
8 for costs incurred and shall be deposited in the fund of the board recovering the costs  
to be available upon appropriation by the Legislature.

9 (i) Nothing in this section shall preclude a board from including the recovery of  
10 the costs of investigation and enforcement of a case in any stipulated settlement.

11 (j) This section does not apply to any board if a specific statutory provision in  
12 that board's licensing act provides for recovery of costs in an administrative  
disciplinary proceeding.

### 13 FACTUAL ALLEGATIONS

14 10. Respondent is a licensed physician and surgeon, board certified in diagnostic  
15 radiology, who at all times relevant to the allegations brought herein worked at Children's  
16 Hospital Los Angeles (CHLA) within Los Angeles County, California.

#### 17 Patient 1<sup>2</sup>

18 11. On or about March 15, 2019, at approximately 1:19 a.m., Patient 1, a 6-month-old  
19 male, presented to the CHLA emergency department (ED) with three days of cough, fever, and  
20 difficulty breathing. Patient 1's vital signs were the following: temperature was 37.8° C, heart  
21 rate of 156 bpm, respiratory rate of 42 breaths/minute, and pulse oximetry at 95%. Upon physical  
22 examination, Patient 1 had coarse wheezing and diffuse rhonchi with chest retractions and  
23 appeared to have tachypnea. A chest X-ray was performed to rule out pneumonia.

24 12. According to Patient 1's medical records, the chest X-ray was preliminarily reviewed  
25 and dictated by CHLA medical resident A.S. on or about March 16, 2019, at approximately 7:33  
26 a.m., whose report findings and impressions stated, "No definite focal consolidation. No pleural

27 <sup>2</sup> To protect the privacy of the patients and witnesses involved, the patients and witnesses  
28 names were not included in this pleading. Respondent is aware of the identity of each patient and  
witness. All patients and witnesses will be fully identified in discovery.

1 effusion or pneumothorax. Normal cardiomeastinal silhouette." This report was signed by  
2 Respondent on or about March 16, 2019 at approximately 9:50 a.m., with the following  
3 statement, "I, Vicente Gilsanz have personally reviewed the images upon which this report is  
4 based and I agree with the findings and conclusions expressed above." Patient 1's medical records  
5 do not include any documentation or differential diagnosis by Respondent as to any opacity,  
6 consolidation, or infiltration in the patient's right lower lung zone.

7 13. According to Patient 1's medical records, the X-ray was viewed and interpreted  
8 independently by the CHLA ED physician on March 16, 2019, at 5:47 a.m., who noted that  
9 contrary to the findings and impressions Respondent signed, there was "c/f RML pneumonia."<sup>3</sup>  
10 Patient 1 was given a presumptive diagnosis of bronchiolitis, rather than pneumonia, and was  
11 discharged home with albuterol for airway constriction and a course of amoxicillin, an antibiotic.

12 14. On or about April 8, 2019, at approximately 2:17 p.m., Patient 1's medical records  
13 were re-reviewed by Dr. F.G. from CHLA, who added that there was evidence of "right lower  
14 lobe infiltration." Contrary to the preliminary and final report signed by Respondent, which  
15 stated, "No definite focal consolidation."

16 15. According to records at CHLA, Respondent opened, reviewed, edited, and then  
17 signed approximately seventy (70) individual radiology reports on the morning of March 16,  
18 2019 within the time span of approximately five (5) minutes. Respondent signed off on numerous  
19 radiology reports between March 15, 2019 and March 17, 2019 without viewing them. Not only  
20 did Respondent sign-off on these numerous unseen radiology reports, but Respondent did not  
21 review the corresponding radiological image(s)/study, including Patient 1's chest X-ray and  
22 report.

23 **Patient 2**

24 16. On or about March 16, 2019, at approximately 3:15 a.m., Patient 2, a 13-year-old  
25 female, presented to the CHLA ED with acute worsening of left lower quadrant pain for a week.  
26 According to Patient 2's medical records, her vital signs were the following: temperature was  
27 36.8° C, heart rate of 80 bpm, and respiratory rate of 16 breaths/minute. Upon physical  
28

<sup>3</sup> In other words, "concern for right middle lobe pneumonia."

1 examination, Patient 2 had moderate tenderness to palpation and some firmness in the left lower  
2 quadrant in which a positive "psoas sign" was noted in her medical records. Patient 2's  
3 documented differential diagnosis included appendicitis, menstrual cramps, or ovarian pathology  
4 including cyst or torsion. An ultrasound of Patient 2's pelvis was ordered to rule-out torsion or  
5 ovarian abnormalities.

6 17. According to Patient 2's medical records, the pelvic ultrasound was preliminarily  
7 interpreted and dictated by CHLA medical resident A.S. on or about March 16, 2019, at  
8 approximately 4:29 a.m., with report findings and impressions of "small pelvic free fluid and an  
9 otherwise normal uterus and ovaries." A CT was recommended if there was concern for  
10 appendicitis. This report was signed by Respondent on or about March 16, 2019, at approximately  
11 9:50 a.m., with the following statement, "I, Vicente Gilsanz have personally reviewed the images  
12 upon which this report is based and I agree with the findings and conclusions expressed above."

13 18. According to records at CHLA, Respondent signed off on several radiology reports  
14 between March 15, 2019 and March 17, 2019 without viewing the report or the corresponding  
15 radiological image(s)/study, including Patient 2's pelvic ultrasound and report.

16 **Patient 3**

17 19. On or about March 16, 2019, at approximately 2:04 a.m., Patient 3, a 4-year-old male,  
18 presented to the CHLA ED after tripping and falling on his right elbow. The patient reported pain  
19 with a reluctance to move the elbow. Upon physical examination, Patient 3 had pain in the elbow  
20 and a decreased range of motion. An X-ray of Patient 3's right elbow was consequently ordered.

21 20. According to Patient 3's medical records, the X-ray of his elbow was preliminarily  
22 interpreted and dictated by CHLA medical resident A.S. on or about March 16, 2019, at  
23 approximately 2:21 a.m., whose report findings and impressions stated, "Small elbow joint  
24 effusion, cannot exclude occult fracture. No definite fracture visualized. No significant soft tissue  
25 swelling." This report was signed by Respondent on or about March 16, 2019 at approximately  
26 9:50 a.m., with the following statement, "I, Vicente Gilsanz have personally reviewed the images  
27 upon which this report is based and I agree with the findings and conclusions expressed above."

28 21. According to records at CHLA, Respondent signed off on several radiology reports

1 between March 15, 2019 and March 17, 2019 without viewing them or the corresponding  
2 radiological image(s)/study, including Patient 3's X-ray and report.

3 **Patient 4**

4 22. On or about March 15, 2019, at approximately 7:30 p.m., Patient 4, a 1-year-old  
5 female, presented to the CHLA ED with seven days of cough, two days of fever, and nasogastric  
6 tube dislodgment. Patient 4's vital signs were the following: temperature was 38.9° C, blood  
7 pressure 102/88, heart rate of 181 bpm, respiratory rate of 64 breaths/minute, and pulse oximetry  
8 at 91-98%. Upon physical examination, Patient 4's lungs had coarse upper airway noises. A chest  
9 X-ray was performed to assess tube position and to look for signs of infection.

10 23. According to Patient 4's medical records, the chest X-ray was preliminarily  
11 interpreted and dictated by CHLA medical resident A.S. on or about March 15, 2019 at  
12 approximately 8:36 p.m., whose report findings and impressions stated, "The weighted feeding  
13 tube tip is within the gastric lumen. Nonspecific bowel gas pattern. No intraperitoneal free air.  
14 The lungs are hyperinflated. Stable chronic bronchovascular markings." This report was signed  
15 by Respondent on or about March 16, 2019, at approximately 9:52 a.m., with the following  
16 statement, "I, Vicente Gilsanz have personally reviewed the images upon which this report is  
17 based and I agree with the findings and conclusions expressed above."

18 24. According to records at CHLA, Respondent viewed Patient 4's chest X-ray on March  
19 16, 2019, at 9:57 a.m., five minutes after he had already signed the report.

20 **Patient 5**

21 25. On or about March 16, 2019, at approximately 2:04 a.m., Patient 5, a 5-year-old  
22 female, presented to the CHLA ED with pain to the right elbow after a fall. According to Patient  
23 5's medical records, a physical examination was conducted with the finding that the elbow was  
24 neurovascularly intact. An X-ray of the right elbow was ordered and a preliminary interpretation  
25 by the CHLA orthopedic surgeon at approximately 7:30 a.m. stated, "supracondylar humerus  
26 fracture... anterior and posterior fat pad signs."

27 26. On or about March 16, 2019, at approximately 9:04 a.m., Patient 5 was taken to a  
28 CHLA operating room for a closed reduction with percutaneous pinning and was subsequently

1 discharged after a successful procedure to fixate the fracture.

2 27. On or about March 16, 2019, at approximately 2:35 a.m., Patient 5's right elbow X-  
3 ray was preliminarily dictated by CHLA medical resident A.S., whose report findings and  
4 impressions stated, "There is an elbow joint effusion, cannot exclude occult fracture. No definite  
5 fracture visualized. Mild soft tissue swelling overlying the dorsal elbow. The bones are well  
6 aligned." According to Patient 5's medical records, this report was signed by Respondent on or  
7 about March 16, 2019, at approximately 9:50 a.m., with the statement, "I, Vicente Gilsanz have  
8 personally reviewed the images upon which this report is based and I agree with the findings and  
9 conclusions expressed above." Patient 5's medical records do not include any documentation or  
10 differential diagnosis by Respondent as to a supracondylar fracture or abnormal anterior humeral  
11 line.

12 28. On or about April 8, 2019, at approximately 2:18 p.m., Patient 5's medical records  
13 were re-reviewed by Dr. F.G. from CHLA, who found that "there is evidence of a supracondylar  
14 fracture."

15 29. According to records at CHLA, Respondent signed off on several radiology reports  
16 between March 15, 2019 and March 17, 2019 without viewing them or the corresponding  
17 radiological image(s)/study, including Patient 5's right elbow X-ray and report.

18 **Patient 6**

19 30. On or about March 15, 2019, at approximately 4:38 p.m., Patient 6, a 4-year-old  
20 male, presented to the CHLA ED with intermittent vomiting and diarrhea for four weeks with  
21 right upper quadrant tenderness and weight loss. According to Patient 6's medical records, his  
22 vital signs were the following: temperature was 38.6° C and heart rate of 103 bpm, with the  
23 patient being mildly febrile. On a physical examination, Patient 6 was noted to have a full  
24 abdomen, but it was soft, non-tender, with normal bowel sounds. At approximately 5:15 p.m.,  
25 initial labs were conducted which indicated signs of dehydration. Consequently, an ultrasound of  
26 the abdomen and computed tomography (CT) of the abdomen and pelvis were ordered and fluids  
27 were given to the patient. Following negative results of the CT of the abdomen and pelvis, Patient

1 6 was discharged with advice to follow up if symptoms persisted.

2 31. According to Patient 6's medical records, the CT of the abdomen and pelvis was  
3 preliminarily reviewed and dictated by CHLA medical resident A.S. on or about March 15, 2019,  
4 at approximately 9:43 p.m., whose report findings and impressions stated, "No evidence of portal  
5 venous gas. Scattered stool is seen throughout a nondilated colon. Trace ascites, likely  
6 physiologic." This report was signed by Respondent on or about March 16, 2019, at  
7 approximately 9:52 a.m., with the following statement, "I, Vicente Gilsanz have personally  
8 reviewed the images upon which this report is based and I agree with the findings and  
9 conclusions expressed above." Patient 6's medical records do not include any documentation or  
10 identification by Respondent as to any portal venous gas.

11 32. According to Patient 6's medical records, the ultrasound of the abdomen was  
12 preliminarily reviewed and interpreted by CHLA medical resident A.S. on or about March 15,  
13 2019, at approximately 9:56 p.m., whose report findings and impressions stated, "Multiple  
14 punctate echogenic foci are seen flowing within the portal vein, with abnormal spikes seen in the  
15 normally monophasic portal venous waveform, upon correlation with concurrent CT abdomen  
16 this most likely represents artifact." This report was signed by Respondent on or about March 16,  
17 2019, at approximately 9:52 a.m., with the following statement, "I, Vicente Gilsanz have  
18 personally reviewed the images upon which this report is based and I agree with the findings and  
19 conclusions expressed above." Patient 6's medical records do not include a pathological finding  
20 of portal venous gas by Respondent based on the ultrasound.

21 33. On or about May 24, 2019, at approximately 2:05 p.m., Patient 6's CT was re-  
22 reviewed by Dr. F.G. from CHLA, who found, "Multiple punctate echogenic foci are seen  
23 flowing within the portal vein, with abnormal spikes seen in the normally monophasic portal  
24 venous waveform, concerning for portal venous gas."

25 34. According to records at CHLA Respondent signed off on several radiology reports  
26 between March 15, 2019 and March 17, 2019 without viewing them or the corresponding  
27 radiological image(s)/studies, including Patient 6's abdominal ultrasound and CT scans of the  
28 abdomen and pelvis and the reports:



1 Patient 7

2 35. On or about March 15, 2019, at approximately 11:23 p.m., Patient 7, a 10-year-old  
3 female, presented to the CHLA ED with left arm pain after falling during a soccer game on or  
4 about February 26, 2019. Patient 7 reported worsening symptoms three days prior. Upon physical  
5 examination, Patient 7's elbow had left forearm tenderness from the wrist to the elbow with mild  
6 swelling and she was unable to pronate or supinate the extremity. X-rays were performed to  
7 assess the left hand, forearm, and elbow.

8 36. According to Patient 7's medical records, the X-rays were preliminarily interpreted  
9 and dictated by CHLA medical resident A.S. on or about March 16, 2019, at approximately 12:44  
10 a.m., whose report findings and impressions stated, "No significant joint effusion. Tiny osseous  
11 fragment near the coronoid process of the ulna possibly representing an additional ossification  
12 center, most likely a fracture. No significant soft tissue swelling. The forearm and hand are  
13 unremarkable." This report was signed by Respondent on or about March 16, 2019, at  
14 approximately 9:51 a.m., with the following statement, "I, Vicente Gilsanz have personally  
15 reviewed the images upon which this report is based and I agree with the findings and  
16 conclusions expressed above."

17 37. According to records at CHLA, Respondent signed off on several radiology reports  
18 between March 15, 2019 and March 17, 2019 without viewing them or the corresponding  
19 radiological image(s)/studies, including Patient 7's X-rays and reports.

20 FIRST CAUSE FOR DISCIPLINE

21 (Gross Negligence)

22 38. Respondent Vicente Gilsanz, M.D. has subjected his Physician's and Surgeon's  
23 Certificate No. A 33800 to disciplinary action under sections 2227 and 2234, as defined by  
24 section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and  
25 treatment of Patients 1, 2, 3, 5, 6 and 7. The circumstances are set forth in paragraphs 9 through  
26 37, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

27 39. Respondent committed gross negligence during the care and treatment of each of  
28 Patients 1, 2, 3, 5, 6 and 7 by failing to review the radiological images/studies of each of Patients

1 1, 2, 3, 5, 6 and 7.

2 40. Respondent committed gross negligence during the care and treatment of each of  
3 Patients 1, 2, 3, 5, 6 and 7 by failing to adequately and properly review the medical resident  
4 radiology diagnostic reports of each of Patients 1, 2, 3, 5, 6 and 7, and nevertheless, signing off  
5 on said diagnostic reports.

6 **SECOND CAUSE FOR DISCIPLINE**

7 **(Repeated Negligent Acts and/or Incompetence)**

8 41. Respondent Vicente Gilsanz, M.D. has further subjected his Physician's and  
9 Surgeon's Certificate No. A 33800 to disciplinary action under sections 2227 and 2234, as  
10 defined by section 2234, subdivisions (c) and (d), of the Code, in that he committed repeated  
11 negligent acts and/or incompetence in his care and treatment of Patients 1, 2, 3, 4, 5, 6, and 7.  
12 The circumstances are as follows:

13 42. The allegations of the First Cause for Discipline, inclusive, are incorporated herein by  
14 reference as if fully set forth. Each of Respondent's acts and/or omissions as set forth in the First  
15 Cause for Discipline, individually, collectively, or in any combination thereof, constitutes  
16 negligence.

17 43. Respondent committed repeated negligent acts in connection with his care and  
18 treatment of patients as follows:

19 **Patient 1**

20 A. On or about March 15, 2019 and thereafter, Respondent committed negligence  
21 in connection with his care and treatment of Patient 1 by failing to adequately describe and  
22 document all the findings and differential diagnoses as to Patient 1, i.e., whether the patient's  
23 right lower lung zone opacity, consolidation, or infiltration could represent atelectasis or  
24 pneumonia.

25 **Patient 4**

26 B. On or about March 15, 2019 and thereafter, Respondent committed negligence  
27 in connection with his care and treatment of Patient 4 by signing a medical resident's diagnostic  
28 study of Patient 4's chest X-ray prior to actually reviewing the radiology study.

1 Patient 5

2 C. On or about March 16, 2019 and thereafter, Respondent committed negligence  
3 in connection with his care and treatment of Patient 5 by signing an inadequate final report which  
4 only raises the possibility of an occult fracture when there is an obvious supracondylar fracture  
5 present with multiple secondary signs. There is a clear fracture line consistent with a  
6 supracondylar fracture. Furthermore, there is an abnormal anterior humeral line, which is a  
7 secondary sign consistent with a supracondylar fracture.

8 Patient 6

9 D. On or about March 15, 2019 and thereafter, Respondent committed negligence  
10 in connection with his care and treatment of Patient 6 by failing to identify portal venous gas in  
11 the final report and incorrectly concluding that there was an artifact. An ultrasound, which is  
12 more sensitive than CT for detecting portal venous gas, was inadequately considered by  
13 Respondent. Portal venous gas can be seen in very serious illnesses such as bowel ischemia as  
14 well as relatively benign disease such as enteritis. Proper identification of portal venous gas is a  
15 very important responsibility of a radiologist. At his interview with a Department of Consumer  
16 Affairs Health Quality Investigation Unit (HQIU) Investigator and medical consultant,  
17 Respondent stated, "So, what would you do if there's concern for something? You would do an x-  
18 ray that is more sophisticated – the- the CT. They didn't find it. Uh – that's- that's it."  
19 Respondent demonstrated that he does not know the nuance and difference in evaluating portal  
20 venous gas with an ultrasound versus a CT, and implies that the CT is the superior and definitive  
21 test.

22 **THIRD CAUSE FOR DISCIPLINE**

23 **(Failure to Maintain Adequate and Accurate Records)**

24 44. Respondent Vicente Gilsanz, M.D. has further subjected his Physician's and  
25 Surgeon's Certificate No. A 33800 to disciplinary action under sections 2227 and 2234, as  
26 defined by section 2266 of the Code, in that he failed to maintain adequate and accurate medical  
27 records of Patients 1, 2, 3, 4, 5, 6 and 7. The circumstances are as follows:

28 45. The allegations of the First and Second Causes for Discipline, inclusive, are

1 incorporated herein by reference as if fully set forth.

2 **FOURTH CAUSE FOR DISCIPLINE**

3 **(Dishonesty, Corrupt Acts and False Representations)**

4 46. Respondent Vicente Gilsanz, M.D. has further subjected his Physician's and  
5 Surgeon's Certificate No. A 33800 to disciplinary action under sections 2234, subdivision (e) and  
6 2261 of the Code in that he has engaged in dishonest, corrupt acts and/or made false  
7 representations in connection with his care and treatment of Patients 1, 2, 3, 4, 5, 6 and 7. The  
8 circumstances are as follows:

9 47. The allegations of the First, Second and Third Causes for Discipline, inclusive, are  
10 incorporated herein by reference as if fully set forth.

11 48. Respondent falsified the records of each of Patients 1, 2, 3, 5, 6 and 7, implying that  
12 he properly reviewed each of the medical resident radiology diagnostic reports and radiologic  
13 studies and images of each of Patients 1, 2, 3, 5, 6 and 7 when, in fact, he did not adequately  
14 review such reports and radiologic studies and images. Respondent falsified medical records and  
15 documented radiology report reviews that did not occur as to Patients 1, 2, 3, 4, 5, 6 and 7.

16 **FIFTH CAUSE FOR DISCIPLINE**

17 **(General Unprofessional Conduct)**

18 49. Respondent Vicente Gilsanz, M.D. has further subjected his Physician's and  
19 Surgeon's Certificate No. A 33800 to disciplinary action under sections 2227 and 2234, as  
20 defined by section 2234 of the Code, in that he has engaged in conduct which breaches the rules  
21 or ethical code of the medical profession, or conduct which is unbecoming of a member in good  
22 standing of the medical profession, and which demonstrates an unfitness to practice medicine as  
23 to his care and treatment of Patients 1, 2, 3, 4, 5, 6, and 7. The circumstances are as follows:

24 50. The allegations of the First, Second, Third and Fourth Causes for Discipline,  
25 inclusive, are incorporated herein by reference as if fully set forth.

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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 No. A 33800, issued to Vicente Gilsanz, M.D.;
2. Revoking, suspending or denying approval of Vicente Gilsanz, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering Vicente Gilsanz, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and
4. Taking such other and further action as deemed necessary and proper.

DATED: MAY 12 2022

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

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